STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455876**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/03/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WOODLANDS HEALTHCARE CENTER	**4650 S PANTHER CREEK DR THE WOODLANDS, TX 77381**

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

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

F 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source were investigated and reported to the Texas Department of Aging and Disability Services (DADS) in accordance with State law through established procedures for 1 of 11 residents (Resident #11) reviewed for abuse.

- Resident #11 suffered a left [MEDICAL CONDITION] of unknown origin. The facility failed to report the incident to DADS.

This failure affected one resident, and placed an additional 84 residents with a [DIAGNOSES REDACTED].

Findings included:

Record review of Resident #11 ' s medical record revealed she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. She was [AGE] years of age.

Record review of Resident #11 ' s significant change MDS assessment dated [DATE] revealed she had a BIMS score of 3, indicating severe cognitive impairment. She required extensive assistance of one person for bed mobility, transfers, dressing, toileting and personal hygiene.

Record review of Resident #11 ' s Care Plan dated 2/5/2016 revealed she required extensive assistance with activities of daily living. .is dependent for ADL care with bathing, grooming, dressing, bed mobility x2 staff, transfer x2 staff, toileting, supervision for (wheelchair) locomotion . due to cognitive loss/dementia. The interventions included .Monitor for pain or discomfort and medicate as appropriate . Encourage resident participation while providing appropriate ADL care . It further revealed she was at risk for falls. Interventions included .Assist resident getting in and out of bed with extensive assistance x 2 staff, Provide verbal cues for safety and sequencing when needed .

In an observation on 2/9/2016 at 10:22am, Resident #11 was lying in bed on her left side. Her bed was low to the ground and there was a fall mat placed on the floor. She was non-interviewable and repeated uh-huh over and over. She did not appear to be in pain.

Record review of Resident #11 ' s nurse notes revealed she complained of left leg pain on 2/11/2016 at 10:37am. When leg is touched or when rolled over resident yells and says her left leg hurts. She was treated for [REDACTED]. On 2/11/2016 at 2:32pm, the x-ray results showed a [MEDICAL CONDITION] hip and she was sent to the hospital.

Record review of the Fall Log dated 2/1/2016- 2/9/2016 and printed on 2/9/2016 at 12:01pm revealed that there was no incident regarding Resident #11.

Record review of a undated document titled ' Timeline for (Resident #11) 2/11/2016 ' read in part . .2/8/2016: 4:25am While performing incontinent care resident had an assisted fall in which she was lowered to the floor. Upon assessment by the charge nurse resident had no complaints of pain, facial grimacing, etc . 2/9/2016: No unusual occurrences or complaints voiced by resident. 2/10/2016: No unusual occurrences or complaints voiced by resident. 2/11/2016: 10:37am Resident complained of left leg pain when touched or rolled over for care . new order received for Tyleenol (sic) 500mg and xray of left hip, left femur, and left (tibia and fibula) . Left hip conclusion reports facture (sic) involving the neck of the femur .Prior to admission resident was thrown from a moving vehicle at 70 (miles per hour) which resulted in a lengthy hospital stay. resident had a history of [REDACTED]. Resident has a current [DIAGNOSES REDACTED]. Upon speaking with resident ' s MD he stated it ' s a possibility that the (fracture) occurred due to resident ' s history .

Record review of a Radiology Report dated 2/11/2016 at 1:30pm revealed that Resident #11 had a .fracture involving the left femoral neck with displacement . May be subacute . Record review of a Addendum Radiology Report dated 2/11/2016 at 6:41pm revealed that the fracture .shows no healing and could be acute or recent. Osteopenia is present.

In an observation on 3/2/2016 at 9:55am, Resident #11 was lying in bed and repeated the word okay. Her bed was low to the ground and there was a fall mat on the floor.

In an interview on 3/2/2016 at 11:30am, LVN P said she was caring for Resident #11 the day she complained of left leg pain. She said she complained of pain when they would reposition her or turn her. She said when she asked where it hurt, she pointed to her left leg. She said she notified the physician and he ordered an x-ray. She said when the results came back, they immediately transferred her to the hospital. She said she had no idea how the fracture occurred. She said Resident #11 may have had something wrong with her bones, but said she did not know what happened. She said the DON, physician, and responsible party were aware of the fracture.

In an interview on 3/3/2016 at 11:35am, when asked how Resident #11 broke her hip, the DON said it occurred when CNA KK provided incontinent care. She said when CNA KK rolled her over towards her, the resident's body became heavy and she had an assisted fall to the ground. She said Resident #11 ' s hip pushed against the bed. She said LVN N assessed her right after the incident and said she was fine. She said about one and one-half day later, she complained of pain. She said Resident #11 was not able to explain what happened. She said they knew exactly how the broken hip occurred because there was a witness to the incontinent care. She said she was not out of her room during that time. She said the incident would have been neglectful if the nursing staff did not follow her plan of care.

In a telephone interview on 3/3/2016 at 3:15pm, when asked how Resident #11 broke her hip, LVN N said she did not know. She said when she worked with her on sometime between 2/7/2016 and 2/9/2016, she did not complain of pain. She said there was an incident when CNA KK was providing incontinent care to the resident and she lowered her to the floor. She said when she assessed Resident #11 that morning she was in bed and did not show signs of pain.

Attempts to contact CNA KK on 3/3/2016 were unsuccessful.

In an interview on 3/3/2016 at 4:00pm, the DON said she did not think the Resident #11 ' s broken hip was an injury of unknown origin. She said they knew the injury occurred during the incontinent care and assisted fall. She said Resident #11 had [DIAGNOSES REDACTED].

In an interview on 3/3/2016 at 5:00pm, the Administrator said she was the abuse coordinator at the facility. After reading the facility definition of an injury of unknown origin, she said Resident #11 ' s broken hip did not fall in that category. She said the injury was witnessed by CNA KK. She said she had a fall and had a [DIAGNOSES REDACTED]. When asked if it could
have occurred between the date she fell and the date she started to complain of pain, she said that was an open ended question and said they investigated the [MEDICAL CONDITION] thoroughly to determine exactly how it occurred. She said the fall was a point of reference to how the injury occurred. She said it would be different if Resident #11 was ambulatory and out of her room during the days after the fall. When asked if she received care during those days, she said of course. When

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 0225

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)
asked if it could have occurred at any other time, she said the facility believed they knew what happened and the injury was not from an unknown source.
Record review of the facility Abuse Prohibition policy sated 10/15/2015 read in part . Injuries of unknown origin are defined as an injury with both of the following conditions. The source of the injury was not observed by any person or the source of the injury could not be explained by the patient; and the injury is suspicious because of the extent of the injury or the location of injury . or the number of injuries observed at one particular point in time or the incidence of injuries over time .Staff will identify events- such as suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property . Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected . Immediately, not to exceed 24 hours, notify the Texas Department on Aging and Disability Services .
According to the CMS Form 672, there were 84 residents with a [DIAGNOSES REDACTED].

F 0309

Level of harm - Actual harm

Residents Affected - Few

Provide necessary care and services to maintain the highest well being of each resident
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest physical well-being in accordance with the comprehensive assessment and plan of care for two of eleven residents (Resident #7 and #9) reviewed for care and services to address pain.
-Resident #7, who had a stage IV pressure sore to his sacrum (large wedge shaped vertebra at the inferior end of the spine), was not assessed for pain prior, during or after the wound dressing change.
-The facility failed to evaluate Resident #7 for pain per facility's policy during admission, quarterly or during change in condition. Resident #7's pain was not adequately controlled.
- The facility failed to adequately control Resident #9's pain.
This failure affected two resident and could place the other two residents receiving wound care at the 200 hallway at risk for experiencing pain unnecessarily.
Findings include:
Record review of Resident #7's face sheet revealed Resident #7 was [AGE] years old. He was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
Record review of Resident #7's care plan reviewed 9/16/15 revealed in part: Resident #7 was at risk for skin breakdown. Further record review revealed that care plan was not updated indicating that Resident #7 had a stage IV pressure sore with interventions in place to assess and treat for pain. Resident #7 did not have a pain care plan.
Record review of Resident #7's Significant change in status assessment MDS dated [DATE] revealed Resident #7 required extensive assistance of two persons for bed mobility, transfer, dressing, toilet use and personal hygiene. Resident #7 was always incontinent of bowel and bladder. Resident #7 was coded as not on any scheduled pain medication regimen and had not received any PRN pain medications. The resident had also not received non-medication intervention for pain. Indicators of Pain or Possible Pain in the last 5 days revealed that Resident #7 was coded as having no signs of non-verbal sounds, vocal complaints of pain, facial expressions and protective body movements of postures observed. Resident #7 had one Stage IV pressure ulcer that was acquired at the facility. The Stage IV pressure ulcer measured 6.0 cm x 3.0 cm x 0.0 cm. (LxWxD).
Record review of electronic assessments revealed no pain assessments during admission, quarterly or during change in condition. Further record review revealed that Resident #7 was admitted to hospice care on 2/1/2016.
Record review of the wound assessment sheet for Resident #7 dated 3-1-2016 revealed the Stage IV pressure sore was located on the sacrum and measured 6.0 cm. x 3.0 cm. x Non-measureable depth. (LxWxD). Further record review revealed that pressure sore was acquired at the facility on 1/8/2016.
Record review of Resident #7's summary of Physician's order dated 3/1/2016 to 3/31/2016 revealed the following orders in part:
- clean sacrum with normal saline, pat dry, apply Santyl to wound bed, cover with water proof dressing every day and as needed loose/soiled in the morning.
-[MEDICATION NAME] ([MEDICATION NAME], narcotic) 20 mg/ml give 0.5 ml every 4 hours as needed for pain.
-[MEDICATION NAME] (narcotic) Tablet 7.5 - 325 mg ([MEDICATION NAME]-[MEDICATION NAME]) Give one tablet by mouth two times
a day for pain.
- [MEDICATION NAME] Tablet 7.5 - 325 mg ([MEDICATION NAME]-[MEDICATION NAME]) Give one tablet by mouth every 6 hours as
needed for pain (give prior to wound care treatment).

Observation on 3/03/2016 at 9:30 a.m. during incontinent care, Resident #7 was noted with a square dressing to his sacral area that was completely soaked with dark brown/red colored drainage. The dressing was peeling off from the top exposing the large circular pressure sore that was noted with an adjacent open area to the left upper part of the pressure sore. Resident #7's brief was noted with a large area of red and dark brown drainage where the wound was located and there was a foul odor coming from the dressing. The underneath pad where Resident #7 was laying on was noted with a large circular red area at the direction where the sacral pressure sore was located. Resident #7 had also an open area to his right upper buttocks that was not protected with a dressing and an open area to his left lower back that was not protected with a dressing either. Further observation revealed that Resident #7 grimaced his face and moaned while he was being turned to his side by C.N.A. DD. Resident #7 was then assisted to his back and C.N.A DD said that she was going to call the wound care nurse so she could change the soiled dressing before proceding with incontinent care.
In an interview on 3/3/2016 at 9:42 a.m. with the Wound care nurse A, she stated that she had already done wound care to Resident #7 before breakfast at around 7:30 a.m. and further said but I can do it again, he has an unstageable pressure sore to his sacrum, he has no other wounds to his buttocks area.
Observation on 3/3/2016 at 9:50 a.m. during wound care to Resident #7's pressure sore to his sacrum, Resident #7 moaned when Wound care nurse A removed the dressing to his sacral pressure sore and continued moaning while the Wound care nurse A cleaned the wound base with a gauze. Further observation revealed that the wound base had 3 areas of approx 1.0 x 1.0 c.m of yellow slough and the rest of the wound base was red and the surrounding skin to the pressure sore was red. Wound care nurse continued with wound care while Resident #7 moaned on and off. C.N.A. DD was assisting the Wound care nurse.
Interview at that time, surveyor asked the Wound care nurse A if Resident #7 would usually moaned during wound care and she responded yes, I usually give him a pain pill 20 to 30 minutes before wound care, but it is not time now for pain medication. Wound care nurse A continued saying that earlier during wound care to Resident #7's sacral pressure sore, he did not have the open areas to his right buttocks, or the open area on top of the sacral pressure sore or the open area to his left lower back. Wound care nurse A further said while measuring the open areas Resident #7's left lower back open area was 1.5 x 0.8 c.m., the open area to his right buttocks was 2.3 x 0.8 c.m. and the open area to the top left adjacent to the sacral pressure sore was 3.0 x 1.0 c.m. all of these open areas are new, they were not there this morning during wound care.
Further observation and interview revealed that Resident #7 continued to moan and grimaced his face at end of wound care/incontinent care and while being assisted to his back by Wound care nurse A and C.N.A. DD. Resident was positioned on his back with his knees and hips bent.
An interview with Resident #7 was attempted on 3/3/16 at 10:24 am; however, the resident was non-responsive to the questions, he kept looking at surveyor while grimacing his face.
In an interview on 3/3/2016 at 11:55 a.m. with MA F, she stated that Resident #7 had orders for schedule pain medication [MEDICATION NAME] (narcotic) at 8:00 a.m. and 5:00 p.m. and that she did not give the medication because the medication was not available in her drawer but that the nurse had given his PRN [MEDICATION NAME] at 7:00 a.m.
In an interview on 3/3/2016 at 2:00 p.m. with LVN D, she stated that she gave [MEDICATION NAME] PRN to Resident #7 at 7:00 a.m. because he was in pain.
In an observation and interview on 3/3/2016 at 2:05 p.m. with C.N.A. DD, she stated that Resident #7 would usually moan during care or when he was moved because of his pain. She further said that she believed that the nurses were aware of his pain. Further observation revealed that as C.N.A DD turned Resident #7 to his side facing the door, he softly moaned and grimaced his face. C.N.A. DD continued saying I worked with Resident #7 yesterday and he had the open areas to his right buttocks and his left lower back, they were smaller, I told the Wound care nurse A about those areas and I saw her putting

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F 0309

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 2)
something but was not sure what, but the areas looked smaller yesterday. Today they are bigger.
In an interview on 3/3/2016 at 2:50 p.m. with the Wound care nurse A, she stated that she would assess the residents with pressure sores for pain at the beginning of the shift in the morning if they complained of pain the day before. She further said that she would assess non-verbal residents for pain by looking for changes in their behavior such as combativeness, moaning, grimacing and that those were indicators that the residents were in pain. When asked if she noticed that Resident #7 was moaning during wound care to his sacral stage IV pressure sore, Wound care nurse A responded Yes, I did notice it. I checked with the nurse and she had given his pain medication at 7:00 a.m. I would usually call the MD if I see that the current pain medication is not working so the MD could revise the pain medications. When asked if she called Resident #7's MD about his pain management, Wound care nurse A responded No, I did not call the MD, but I did let the nurses know that he was in pain but she had already given his medication at 7:00 a.m.
Resident #9
Record review of Resident #9's face sheet revealed Resident #9 was [AGE] years old. She was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
Record review of Resident #9's care plan reviewed 1/25/16 revealed in part: Resident #9 is at risk for skin breakdown as evidenced by limited mobility and incontinence. -Goal: Resident #9 will not show signs of skin breakdown in 90 days with a target date of 4/25/2016. Interventions: Assist resident in repositioning as tolerated, utilize positioning devices as appropriate to prevent pressure over bony prominences.
Record review of Resident #9's Admission assessment MDS dated [DATE] revealed Resident #9 required extensive assistance for bed mobility, dressing, personal hygiene and bathing and required total assistance from staff for toilet use. She was always incontinent of bowel and had an Indwelling catheter. Resident #9 was identified at risk of developing pressure ulcers and did not have a pressure sore. Further record review revealed that Resident #9 was not on a turning/repositioning program.
Record review of electronic Braden Scale for Predicting Pressure Sore Risk assessments dated 2/3/2016 revealed Resident #9 had a score of 17 indicating mild risk.
Record review of Resident #9's telephone orders dated 3/3/2016 revealed orders that read:
-Apply Zinc to coccyx with every incontinent care and as needed.
Observation and interview on 3/03/2016 at 8:50 a.m. revealed Resident #9 was lying in a regular mattress on her back. Further observation and interview, Resident #9 stated I have a bed sore on my buttocks, is sore, it's been there for about a month. When asked if staff would come to turn her and reposition her, Resident #9 stated No, I have to tell them, my buttocks gets really sore. Resident #9 continued saying that she still did not have incontinent care done and that she believe that her brief probably needed to by changed.
In an interview on 3/3/2016 at 9:03 a.m. with C.N.A. OO, she stated that she did not know anything about Resident #9 and that she would usually work on the other side of the facility. She further stated that she still did not do incontinent care to Resident #9 and that she could do incontinent care at that time.
Observation on 3/3/2016 at 9:10 a.m. during incontinent care revealed that Resident #9's coccyx bone area noted with a large circular dark reddened area approx 8.0 x 8.0 c.m with an open area in the middle of approx 3.0 x 2.0 c.m. wound base was red.
Further observation at that moment revealed that after C.N.A. OO finished providing pericare to Resident #9, she preceded to position her to her back. Resident #9 immediately told C.N.A. OO turn me on my side please because my buttock's sore hurts . C.N.A. OO then assisted Resident #9 to her side facing the door.
In an interview on 3/3/2016 at 10:25 a.m. with the Wound care nurse A, she stated that nurses had reported in the morning that the family member of Resident #9 had come to the facility the day before and had yelled at them because she had discovered a pressure sore to Resident #9's buttocks area and that the family member had taken pictures of the pressure sore. The Wound care nurse A further said that nobody made any reports of Resident #9's having a pressure sore before this morning and that she had already assessed the pressure sore and that it was a Stage 2 pressure sore that measured 3.0 x 2.0 c.m. with shattered edged. She continued saying that she had just gotten wound care orders this morning.
In an interview on 3/3/2016 3:47 p.m. with the DON, she stated that pain assessments were supposed to be completed in the computer. Further interview and observation, DON looked at the computer and said I can not locate any pain assessment for Resident #7. The DON continued flipping thru Resident #7's chart and said I don't see any pain assessments for Resident #7 and they were not filed with medical records either . The DON continued saying that residents are assessed for pain before wound care and if residents were on pain during wound care, the nurse is supposed to stop the wound care and medicate the resident appropriately or call the MD. The DON further said that if residents are not able to verbalize pain, then the staff is supposed to monitor for signs of non-verbal clues for pain such as grimacing or moaning they have to make sure the patients are comfortable and come back later . The DON then said that pain assessments were supposed to be completed upon admission, then quarterly or if changes in pain. She further said that is a group effort to complete and monitor the pain assessments and not one person was responsible.
In a second interview on 3/3/2016 at 4:30 p.m. with the DON, she stated that the facility protocol to prevent and treat pressure sores was to turn and reposition residents and further said we have to make sure that residents who cannot turn by themselves, we turn them and reposition them and even that they are in air mattresses, they still need to be turn and reposition. Is a team effort to monitor that residents are turn and reposition. The expectation is that if the C.N.A's sees any new changes in skin condition, to report it to the nurses right away, we had recently implemented a skin sheet, C.N.A's are supposed to know about those sheets and the nurses are supposed to get orders as soon as possible. The Wound care nurse A told me that Resident #7 had a couple of new open wound and that they were shearing areas.
Record review of the facility policy and procedure Pain Management revised 01/02/2014 revealed in part: .Patients will be evaluated as part of the nursing assessment process for presence of pain upon admission/re-admission, quarterly, with change in condition or change in pain status, and as required by the state thereafter. Purpose: To maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain and to design a plan of care to achieve an optimal balance between pain relief and preservation of function, in accordance with patient directed goals. 3.- An individualized, interdisciplinary care plan will be developed and include pharmacological and non-pharmacological approaches. 10.- The care plan will be evaluated for effectiveness until satisfactory pain management is achieved. Contact the physician/mid-level provider to report finding and obtain revised treatment orders, if indicated, review the non-pharmacological approaches for effectiveness and revise the care plan as indicated .
Record review of the facility undated policy and procedure with title Skin/wound management revealed in part: Pain management: Manage pain per pain assessment. Evaluate before, during and after dressing changes. Daily monitoring of an ulcer during a dressing change includes: Wound pain, if present, is being adequately controlled.
The facility's wound report dated 3/1/2016 indicated 4 residents with pressure sores that required wound care in the 200 hallway.

F 0314

Level of harm - Actual harm

Residents Affected - Few

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review, the facility failed to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstratres that they were unavoidable, and failed to provide the necessary treatment and services to promote the healing of pressure ulcers and prevent new sores from developing for two residents (Resident #7 and Resident #9) of eleven residents reviewed for skin breakdown.
-The facility failed to assess Resident #7's level of risk for pressure ulcer development at admission and quarterly per facility's policy and he acquired a Stage IV pressure sore to his sacrum (large wedge shaped vertebra at the inferior end of the spine) 5 months after admission to the facility.
-The facility failed to develop a care plan to Resident #7's Stage IV pressure sore with specific interventions to alleviate and prevent further wound development and he then developed open wounds to his left lower back, sacral area above the Stage

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F 0314

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 3)
IV pressure sore and right upper buttocks area which were not appropriately assessed and reported to the MD according to facility policy.
-The facility failed to routinely turn and reposition Resident #7 and Resident #9 to prevent worsening of the pressure sores or the development of new pressure sores.
-Resident #9 acquired a Stage II Pressure Ulcer to the coccyx (tail bone) and wound treatment orders were not obtained until family intervention.
These failures affected 2 residents and placed an additional 78 residents that were receiving preventive skin care at risk to develop new pressure sores for a decline in health, not receiving adequate treatment and delayed healing and/or worsening of pressure sores.
Findings included:
Resident #7
Record review of Resident #7's face sheet revealed Resident #7 was [AGE] years old. He was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
Record review of Resident #7's care plan reviewed 9/16/15 revealed in part: Resident #7 is at risk for skin breakdown. Further record review revealed that care plan was not updated indicating that Resident #7 had a stage IV pressure sore with interventions in place to assess and treat for pain. Resident #7 did not have a pain care plan.
Record review of Resident #7's Significant change in status assessment MDS dated [DATE] revealed Resident #7 required extensive assistance of two persons for bed mobility, transfer, dressing, toilet use and personal hygiene. Resident #7 was always incontinent of bowel and bladder. Resident #7 was coded as not on any scheduled pain medication regimen and had not received any PRN pain medications. The resident had also not received non-medication intervention for pain. Indicators of Pain or Possible Pain in the last 5 days revealed that Resident #7 was coded as having no signs of non-verbal sounds, vocal complaints of pain, facial expressions and protective body movements of postures observed. Resident #7 had one Stage IV pressure ulcer that was acquired at the facility. The Stage IV pressure ulcer measured 6.0 cm x 3.0 cm x 0.0 cm. (LxWxD).
Record review of electronic records revealed that Resident #7 did not have a Braden Scale assessment (to assess the patient's level of risk for development of pressure ulcers) during admission, quarterly or during change in condition.
Record review of electronic assessments revealed no pain assessments during admission, quarterly or during change in condition. Further record review revealed that Resident #7 was admitted to hospice care on 2/1/2016.
Record review of the wound assessment sheet for Resident #7 dated 3-1-2016 revealed the Stage IV pressure sore was located on the sacrum and measured 6.0 cm. x 3.0 cm. x Non-measurable depth. (LxWxD). Further record review revealed that pressure sore was acquired at the facility. Further review revealed the pressure sore was acquired at the facility on 1/8/2016.
Record review of Resident #7's summary of Physician's order dated 3/1/2016 to 3/31/2016 revealed the following orders in part:
- clean sacrum with normal saline, pat dry, apply Santyl to wound bed, cover with water proof dressing every day and as needed loose/soiled in the morning. Further record review revealed no wound care orders for the open wounds to his left lower back, sacral area above the Stage IV pressure sore and right upper buttocks area.
In an Observation and interview on 3/03/2016 at 9:25 a.m. revealed Resident #7 was on an air loss mattress on his back. Further observation and interview revealed that Resident #7 was non-verbal to surveyor. C.N.A D.D. said she was going to do incontinent care to Resident #7.

Observation on 3/03/2016 at 9:30 a.m. during incontinent care, Resident #7 was noted with a square dressing to his sacral area that was completely soaked with dark brown/red colored drainage. The dressing was peeling off from the top exposing the large circular pressure sore that was noted with an adjacent open area to the left upper part of the pressure sore. Resident #7 ' s brief was noted with a large area of red and dark brown drainage where the wound was located and there was a foul odor coming from the dressing. The underneath pad where Resident #7 was laying on was noted with a large circular red area at the direction where the sacral pressure sore was located. Resident #7 had also an open area to his right upper buttocks that was not protected with a dressing and an open area to his left lower back that was not protected with a dressing either. Further observation revealed that Resident #7 grimaced his face and moaned while he was being turned to his side by C.N.A. DD. Resident #7 was then assisted to his back and C.N.A DD said that she was going to call the wound care nurse so she could change the soiled dressing before preceding with incontinent care.
In an interview on 3/3/2016 at 9:42 a.m. with the Wound care nurse A, she stated that she had already done wound care to Resident #7 before breakfast at around 7:30 a.m. and further said but I can do it again, he has an unstageable pressure sore to his sacrum, he has no other wounds to his buttocks area.
Observation on 3/3/2016 at 9:50 a.m. during wound care to Resident #7 ' s pressure sore to his sacrum, Resident #7 moaned when Wound care nurse A removed the dressing to his sacral pressure sore and continued moaning while the Wound care nurse A cleaned the wound base with a gauze. Further observation revealed that the wound base of the sacral pressure sore had 3 areas of approx 1.0 x 1.0 c.m of yellow slough and the rest of the wound base was red and the surrounding skin to the pressure sore was red. Wound care nurse continued with wound care while Resident #7 moaned on and off. C.N.A. DD was assisting the Wound care nurse.
Interview at that time, surveyor asked the Wound care nurse A if Resident #7 would usually moaned during wound care and she responded yes, I usually give him a pain pill 20 to 30 minutes before wound care, but it is not time now for pain medication. Wound care nurse A continued saying that earlier during wound care to Resident #7's sacral pressure sore, he did not have the open areas to his right buttocks, or the open area on top of the sacral pressure sore or the open area to his left lower back. Wound care nurse A further said while measuring the open areas Resident #7's left lower back open area was 1.5 x 0.8 c.m., the open area to his right buttocks was 2.3 x 0.8 c.m. and the open area to the top left adjacent to the sacral pressure sore was 3.0 x 1.0 c.m. all of these open areas are new, they were not there this morning during wound care.
Further observation and interview revealed that Resident #7 continued to moan and grimaced his face at end of wound care/incontinent care and while being assisted to his back by Wound care nurse A and C.N.A. DD. Resident was positioned on his back with his knees and hip bended.
An interview with Resident #7 was attempted on 3/3/16 at 10:24 am; however, the resident was non-responsive to the questions, he kept looking at surveyor while grimacing his face. The resident was lying on his back.
Observation on 3/3/2016 at 12:37 p.m. revealed Resident #7 was still in the same position on his back with his knees and hips bent. Resident #7 was non-verbal to surveyor.
Observation on 3/3/2016 at 1:57 p.m. revealed Resident #7 was still on his back with his knees and hips bent.
In an interview on 3/3/2016 at 2:05 p.m. with C.N.A. DD, when asked if Resident #7 was on a turning and repositioning schedule, C.N.A. DD responded I don't know if he is on a turning schedule but I am supposed to turn and reposition residents every 2 hours. When asked if she had already turned and repositioned Resident #7, C.N.A. DD responded let me go and get a pillow first. Further interview and observation, C.N.A. DD grabbed a pillow and walked towards Resident #7's room and said the pillow will be for his back, let me turn him now. C.N.A. DD further said that Resident #7 would usually moan during care or when he was moved because of his pain. She further said that she believed that the nurses were aware of his pain. Further observation revealed that as C.N.A DD turned Resident #7 to his side facing the door, he softly moaned and grimaced his face. C.N.A. DD continued saying I worked with Resident #7 yesterday and he had the open areas to his right buttocks and his left lower back, they were smaller, I told the Wound care nurse A about those areas and I saw her putting something but was not sure what, but the areas looked smaller yesterday. Today they are bigger.
Further interview at that time with C.N.A. DD, she stated that she was not aware of any forms that needed to be completed when reporting new skin problems to the nurses and said that whenever they see a new skin problem, they would make the reports verbally.
In an interview on 3/3/2016 at 2:50 p.m. with the Wound care nurse A, she stated that she would assess the residents with pressure sores for pain at the beginning of the shift in the morning if they complained of pain the day before. She further said that she would assess non-verbal residents for pain by looking for changes in their behavior such as combativeness, moaning, grimacing and that those were indicators that the residents were in pain. When asked if she noticed that Resident #7 was moaning during wound care to his sacral stage IV pressure sore, Wound care nurse A responded Yes, I did noticed it. I checked with the nurse and she had given his pain medication at 7:00 a.m. I would usually call the MD if I see that the

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) current pain medication is not working so the MD could revise the pain medications. When asked if she called Resident #7's MD about his pain management, Wound care nurse A responded No, I did not call the MD, but I did let the nurses know that he was in pain but she had already given his medication at 7:00 a.m. Further interview at that time, Wound care nurse A said that residents are supposed to be turned and repositioned every 2 hours to prevent and treat pressure sores. She further stated that the facility policy was that when new skin conditions were reported that the MD needed to be contacted as soon as possible for new orders and update the care plan. Wound care nurse A continued saying that she was not in charge of monitoring the C.N.A's for turning and reposition the residents and that it was the job of the charge nurses on the floor. She continued saying that she was not involved in updating the care plans of the residents including care plans for pressure sores and that she was not in charge of completing Braden Scale assessment (to assess the patient ' s level of risk for development of pressure ulcers) or pain assessments either, that she believed the charge nurses were supposed to complete them. In an interview on 3/3/2016 3:47 p.m. with the DON, she stated that pain assessments and Braden Scale assessment (to assess the patient's level of risk for development of pressure ulcers) were supposed to be completed in the computed. Further interview and observation, DON looked at the computer and said I cannot locate any pain assessment or Braden Scale assessments for Resident #7. The DON continued flipping thru Resident #7's chart and said I don't see any pain assessments or Braden Scale assessments for Resident #7 and they were not filed with medical records either. The DON continued saying that residents are assessed for pain before wound care and if residents were on pain during wound care, the nurse is supposed to stop the wound care and medicate the resident appropriately or call the MD. The DON further said that if residents are not able to verbalize pain, then the staff is supposed to monitor for signs of non-verbal clues for pain such as grimacing or moaning they have to make sure the patients are comfortable and come back later. The DON then said that pain assessments and Braden Scale assessments were supposed to be completed upon admission, then quarterly or if changes in pain or new skin conditions. She further said that is a group effort to complete and monitor the pain and Braden Scale assessments and not one person was responsible. Further interview with DON at that time, she stated that care plans were supposed to be updated by the MDS and monitored by the DON and continued saying from today on, we will be very specific and will talk in the morning meetings about wound care so the MDS nurse can update the care plans during the meetings. In an interview on 3/3/2016 at 4:08 p.m. with LVN D, she stated that she was the charge nurse for Resident #7 but that she was not really monitoring if he would get turn and repositioned every 2 hours and further said If the C.N.A ' s call me for something, I can help but I don't really monitor the turning. Resident #9 Record review of Resident #9's face sheet revealed Resident #9 was [AGE] years old. She was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's care plan reviewed 1/25/16 revealed in part: Resident #9 is at risk for skin breakdown as evidenced by limited mobility and incontinence. -Goal: Resident #9 will not show signs of skin breakdown in 90 days with a target date of 4/25/2016. Interventions: Assist resident in repositioning as tolerated, utilize positioning devices as appropriate to prevent pressure over bony prominences. Record review of Resident #9's Admission assessment MDS dated [DATE] revealed Resident #9 required extensive assistance for bed mobility, dressing, personal hygiene and bathing and required total assistance from staff for toilet use. She was always incontinent of bowel and had an Indwelling catheter. Resident #9 was identified at risk of developing pressure ulcers and did not have a pressure sore. Further record review revealed that Resident #9 was not on a turning/repositioning program. Record review of electronic Braden Scale for Predicting Pressure Sore Risk assessments dated 2/3/2016 revealed Resident #9 had a score of 17 indicating mild risk. Record review of Resident #9's telephone orders dated 3/3/2016 revealed orders that read: -Apply Zinc to coccyx with every incontinent care and as needed. Observation and interview on 3/03/2016 at 8:50 a.m. revealed Resident #9 was lying in a regular mattress on her back. Further observation and interview, Resident #9 stated I have a bed sore on my buttocks, is sore, it's been there for about a month. When asked if staff would come to turn her and reposition her, Resident #9 stated No, I have to tell them, my buttocks gets really sore. Resident #9 continued saying that she still did not have incontinent care done and that she believe that her brief probably needed to by changed. In an interview on 3/3/2016 at 9:03 a.m. with C.N.A. OO, she stated that she did not know anything about Resident #9 and that she would usually work on the other side of the facility. She further stated that she still did not do incontinent care to Resident #9 and that she could do incontinent care at that time. Observation on 3/3/2016 at 9:10 a.m. during incontinent care revealed that Resident #9's coccyx bone area noted with a large circular dark reddened area approx 8.0 x 8.0 c.m with an open area in the middle of approx 3.0 x 2.0 c.m. wound base was red. Further observation at that moment revealed that after C.N.A. OO finished providing pericare to Resident #9, she preceded to position her to her back. Resident #9 immediately told C.N.A. OO turn me on my side please because my buttock's sore hurts . C.N.A. OO then assisted Resident #9 to her side facing the door. In an interview on 3/3/2016 at 10:25 a.m. with the Wound care nurse A, she stated that nurses had reported in the morning that the family member of Resident #9 had come to the facility the day before and had yelled at them because she had discovered a pressure sore to Resident #9's buttocks area and that the family member had taken pictures of the pressure sore. The Wound care nurse A further said that nobody made any reports of Resident #9's having a pressure sore before this morning and that she had already assessed the pressure sore and that it was a Stage 2 pressure sore that measured 3.0 x 2.0 c.m. with shattered edged. She continued saying that she had just gotten wound care orders this morning. In a second interview on 3/3/2016 at 4:30 p.m. with the DON, she stated that the facility protocol to prevent and treat pressure sores was to turn and reposition residents and further said we have to make sure that residents who cannot turn by themselves, we turn them and reposition them and even that they are in air mattresses, they still need to be turn and reposition. Is a team effort to monitor that residents are turn and reposition. The expectation is that if the C.N.A's sees any new changes in skin condition, to report it to the nurses right away, we had recently implemented a skin sheet, C.N.A's are supposed to know about those sheets and the nurses are supposed to get orders as soon as possible. The Wound care nurse A told me that Resident #7 had a couple of new open wound and that they were shearing areas. Record review of the facility's policy and procedure revised on 12/08/2014 with title Skin Integrity Management revealed in part: .The implementation of an individual patient ' s skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed. -Practice Standards: Complete risk evaluation on admission, weekly for the first month, quarterly and with significant change in condition, Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. Review care plan weekly and revise as indicated . Record review of the facility' undated policy and procedure with title Pressure Ulcer prevention guidelines revealed in part: .Encourage frequent repositioning/weight shifting. Position body with pillows and foam support devices. Turn individual at oblique angles to avoid pressure over bony prominences. Risk factors: Impaired/decreased mobility function: Individualized positioning and repositioning schedule Record review of the facility policy and procedure Pain Management revised 01/02/2014 revealed in part: .Patients will be evaluated as part of the nursing assessment process for presence of pain upon admission/re-admission, quarterly, with change in condition or change in pain status, and as required by the state thereafter. Purpose: To maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain and to design a plan of care to achieve an optimal balance between pain relief and preservation of function, in accordance with patient directed goals. 3.- An individualized, interdisciplinary care plan will be developed and include pharmacological and non-pharmacological approaches. 10.- The care plan will be evaluated for effectiveness until satisfactory pain management is achieved. Contact the physician/mid-level provider to report finding and obtain revised treatment orders, if indicated, review the non-pharmacological approaches for effectiveness and revise the care plan as indicated . Record review of the facility undated policy and procedure with title Skin/wound management revealed in part: Pain management: Manage pain per pain assessment. Evaluate before, during and after dressing changes. Daily monitoring of an

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) ulcer during a dressing change includes: Wound pain, if present, is being adequately controlled The facility's CMS dated 3/3/2016 revealed 80 residents receiving preventive skin care.
F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one (Resident #9) of one resident reviewed for indwelling catheters received appropriate treatment and services. · The facility failed to ensure Resident #9's indwelling urinary catheter was secured to prevent movement and urethral traction. This failure affect one resident and could place the 7 residents with Foley catheters at risk for discomfort, urethral trauma and urinary tract infections. Findings included: Record review of Resident #9's face sheet revealed Resident #9 was [AGE] years old. She was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's care plan reviewed 1/25/16 revealed in part: Resident #9 requires indwelling foley catheter due to having [MEDICAL CONDITION]. Further record review of care plan revealed no interventions to maintain indwelling urinary catheter was secured to prevent movement and urethral traction. Record review of Resident #9's Admission assessment MDS dated [DATE] revealed Resident #9 required extensive assistance for bed mobility, dressing, personal hygiene and bathing and required total assistance from staff for toilet use. She was always incontinent of bowel and had an Indwelling catheter. Record review of Resident #9's Medication Review Report revealed orders dated 01/14/2016 in part: -Foley catheter 14 French care every shift for Urine retention. Observation on 3/3/2016 at 9:10 a.m. during incontinent care revealed that Resident #9's catheter tube was not secured to the resident's body to prevent the tube from pulling on her. Further observation at that moment revealed catheter tube pulled and stretched tight while Resident #9 was turned to her side during incontinent care. In an observation and interview on 3/3/2016 at 2:16 p.m. with LVN H, she stated that she was the charge nurse for Resident #9 and that she was not aware that she did not have her urinary catheter tube secure. She further said that urinary catheter tubes are supposed to be attached to the resident's leg and that C.N.A. were supposed to report to the nurses whenever they see a problem with the urinary catheters. Continued interview and observation inside Resident #9's room, LVN H stated I will go and get her something to keep the tube from moving. Interview at that time with Resident #9, she stated that sometimes the urinary catheter tube gets pulled during care. In an interview on 3/3/2016 at 3:53 p.m. with the DON, she stated that urinary catheter tubes needed to be secure to the resident's leg and that the charge nurses and C.N.A ' s were in charge of monitoring and further said Will do an in-service. Record review of the facility policy and procedure revised 1/2/2014 revealed in part: Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor Further record review revealed no information on securing the indwelling urinary catheter to prevent movement and urethral traction. The CMS 272 dated 3/3/2016 revealed 8 residents with indwelling or external catheters.
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 2 of 11 residents (CR #1 and Resident #9) reviewed for medications were free from unnecessary medications. -CR #1 was prescribed [MEDICATION NAME] and [MEDICATION NAME], antipsychotic medications, without an appropriate diagnosis. Nursing staff were not monitoring for target behaviors or side effects. - Resident #9 was prescribed [MEDICATION NAME], antipsychotic medication, without an appropriate consent from her responsible part. Nursing staff were not monitoring for target behaviors or side effects. This failure affected one discharged resident and one resident residing at the facility and placed the remaining 34 residents receiving antipsychotic medications at risk for receiving unnecessary medications. Findings Include: CR #1 Record review of CR #1 ' s medical record revealed he was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. He was [AGE] years of age. He was discharged from the facility on 2/6/2016 after a change in condition. Record review of an annual MDS assessment dated [DATE] revealed he had a BIMS score of 1, indicating severe cognitive impairment, and had fluctuating disorganized thinking. It further revealed he had no signs or symptoms of [MEDICAL CONDITION] or behaviors, and his active [DIAGNOSES REDACTED]. He required supervision for walking on the unit and used a walker. According to his fall history, he did not have any falls since admission or reentry. Record review of CR #1 ' s medical record revealed he was admitted to the hospital on [DATE] after a fall. A nurse note dated 12/17/2015 read in part . (CR #1) was admitted to the hospital. Scans showed he had an old bleed in the brain and currently has a new bleed . He was readmitted to the facility on [DATE]. Record review of CR #1 ' s Hospital Records dated 12/17/2015 read in part . .He has had 2 or 3 falls in the last few days. Today, he was found to be more altered and more agitated . CT scan in the ER showed a subdural hematoma which was possibly acute versus chronic He is confused and intermittently agitated, and trying to get out of the bed. Soft restraints are needed to keep him in place .History of Alzheimer ' s dementia, [MEDICAL CONDITION], hypertension, [MEDICAL CONDITION] and recurrent falls . we will give [MEDICATION NAME] him (sic) as needed for agitation . Record review of CR #1 ' s medical [DIAGNOSES REDACTED]. Record review of CR #1 ' s Care Plan dated 11/1/2014 revealed there was no problem/need, goal, or approach for behaviors or anti-psychotic medication use. Record review of a significant change MDS assessment dated [DATE] revealed he had a BIMS score of 0, indicating severe cognitive impairment, and had fluctuating inattention, disorganized thinking, altered level of consciousness, and psychomotor [MEDICAL CONDITION]. He also had signs of hallucinations and physical and verbal behaviors 1 to 3 days of the week. The behaviors exhibited did not have an impact on the resident or others. It further revealed walking and locomotion no longer occurred, he was not steady, and he was using a wheelchair. His active [DIAGNOSES REDACTED]. Record review of CR #1 ' s Physician ' s Orders revealed the following: - The physician ' s orders dated December 2015 revealed he was not prescribed an antipsychotic medication. - admission orders [REDACTED]. MD A signed the orders on 1/5/2016. - A telephone order dated 12/22/2015 revealed [MEDICATION NAME] 0.5mg, take two tablets by mouth every 8 hours, was discontinued and two new orders were received: [MEDICATION NAME] 0.5mg, take one tablet by mouth twice daily, and [MEDICATION NAME] 1mg, take one tablet by mouth every evening. The diagnosis/problem was for agitation. The order was signed by MD A on 1/5/2016. - A telephone order dated 12/28/2015 revealed an order for [REDACTED]. - A telephone order dated 12/29/2015 revealed that [MEDICATION NAME] 2mg, one tablet by mouth every 4 hours, was discontinued. A new order was received for [MEDICATION NAME] 5mg, take one tablet by mouth every 4 hours as needed for agitation. The order was signed by MD A on 1/5/2016. - A telephone order dated 1/9/2016 revealed a new order for [MEDICATION NAME] 1mg, take one tablet by mouth every 6 hours as

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F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) needed for agitation. The diagnosis/problem was (increased) agitation. The order was signed by MD A on 1/19/2016. - An order dated and signed by MD B on 1/7/2016 revealed an order to discontinue as needed [MEDICATION NAME]. It also notified the staff to add [DIAGNOSES REDACTED]. Record review of CR #1 ' s Nurse Notes revealed the following: - Nurse notes dated 10/1/2015 to 12/22/2015 revealed he did not display signs of [MEDICAL CONDITION] or behaviors. - 12/22/2015 at 6:06pm: spoke to family regarding pt. hesitance to sit in chair and follow fall precautions put in place s/p fall 1 day. And previous fall resulting in hemorrhage. (new order) change [MEDICATION NAME] to 0.5mg (twice daily) and [MEDICATION NAME] 1mg (every evening) . - 12/22/2015 at 6:09pm: Resident needs to be on continues (sic) watch. He keeps trying to get out of wheelchair to walk. Resident is unsteady and a high fall risk . - 12/22/2015 at 9:01pm: Observed with behavior concerns, very anxious and agitated attempting to stand up from wheelchair-unassisted. Resident re-oriented constantly and monitored closely to avoid falls. - 12/22/2015 at 11:50pm: [MEDICATION NAME] (generic name for [MEDICATION NAME]) 1mg tab administered by mouth for agitation and confusion behaviors (sic). Medication effective. Resident resting in bed sleeping comfortable. - 12/24/2015 at 5:57pm: Does not follow instructions. Continues to attempt to attempt (sic) to ambulate. Very unsteady. Had therapy this afternoon. Per therapist, ambulated with walker with therapist at this side. - 12/26/2015 at 6:4pm: Resident was awake this morning taking off clothes and wont (sic) keep diaper on .He is not sitting in front of the nurses (sic) station. Will continue to monitor. - 12/27/2015 at 11:10pm: Resident remains agitated and unable to sleep. SN transferred resident to Nurses station to watch for safety. Resident continues show intermittent confusion and hallucination. SN administered scheduled Risperidol 1mg tab (by mouth) for agitation. Resident kept in nurses (sic) station for close watch to provide safety. - 12/28/2015 at 12:45am: Resident becomes combative and increasing agitated unable to remain sit on Wheelchair keeps making repeated attempt to get up out of wheelchair . - 12/28/2015 at 8:51pm: Resident agitated and restless speaking occasional abstract words, fewer legible words spoken. Repeatedly getting up out of wheelchair without assist with generalized weakness. Gait very unsteady. SN reorient, instruct to sit down. Resident unable to follow instruction . - 12/28/2015 at 9:30pm: Resident increasingly anxious taking off clothes and smashing his eye-glasses to the nurses (sic) station desk. Very aggressive and combative when confronted . Notify family spoke to daughter, informed about behavior decline and need for medication to be administered. Family verbalize (sic) understanding. - 12/30/2015 at 3:50am: Resident restless and mildly agitated this night and unable to this AM. Scheduled Risperdone 1mg at 12 MN (sic) not very effective. NO aggressive behavior this shift. Resident lying on recliner in nurse ' s station intermittently awake from sleep due to agitation. Record review of CR #1 ' s medical record revealed that there were no consents for the [MEDICATION NAME] and [MEDICATION NAME] medications or behavior and side-effect monitoring charts. In an interview on 3/5/2016 at 11:35am, the DON said she would try to locate them. Record review of a Psychoactive Medication Acknowledgment dated 12/20/2015 and provided by the DON on 3/5/2016 at 12:35pm revealed that CR #1 ' s responsible party consented to [MEDICATION NAME] by telephone on 12/20/2015. It further revealed the medication was used to treat [MEDICAL CONDITION] disorder and agitation .manifested by: mood swings. Record review of the Quality Improvement: Consultant Pharmacist Summary dated 1/22/2016 and 2/22/2016 revealed that isolated issues were observed in medications having appropriate diagnoses/indications for use and behavior monitoring documentation and identifying target behaviors. The Report dated 1/22/2016 further revealed the pharmacist recommended for the facility to .make sure completed consent forms are available for all psychoactive meds. Record review of CR #1 ' s MAR indicated [REDACTED] - CR #1 received 1 tablet of [MEDICATION NAME] 2mg, ordered every 4 hours and as needed for agitation, on 12/21/2015. - CR #1 received [MEDICATION NAME] 5mg, ordered every 4 hours as needed for agitation, once on 12/29/2015, 1/5/2016, 1/6/2016, and 1/7/2016, and four times on 12/30/2015. The December and January MAR indicated [REDACTED]. - CR #1 received [MEDICATION NAME] 1mg, ordered once daily every evening, on 12/22/2015, 12/24/2015, 12/25/2015, 12/26/2015, 12/27/2015, 12/28/2015, and 12/31/2015-2/6/2016. - CR #1 received 2 tablets of [MEDICATION NAME] 0.5mg, ordered twice daily, on 12/23/2015-2/6/2015. - CR #1 received 1 tablet of [MEDICATION NAME] 1mg, ordered every 6 hours as needed, on 1/12/2016. In an interview on 2/9/2016 at 2:30pm, ADON B said CR #1 had a fall in December that caused a decline. She said he had a subdural hemmorage and it was unsafe for him to walk like he used to. She said he required two people to assist him with walking. She said when he returned from the hospital, they placed him in a wheelchair. She said CR #1 had panic attacks and it would affect other residents, and also became combative with staff. She said he would attempt to get out of his chair. She said the [MEDICATION NAME] and [MEDICATION NAME] were prescribed for his behaviors and because he was restless in the wheelchair. In an interview on 2/9/2016 at 2:40pm, LVN D said she cared for CR #1. She said he would always attempt to get out of his wheelchair. She said it was unsafe for him to walk so he was given [MEDICATION NAME] for the agitation. She said the medication was effective. In an interview on 2/9/2016 at 4:15pm, CR #1 ' s family member said when she visited her father after he fell in December he was like a zombie and was not very responsive. She said she and her family asked the facility multiple times to stop giving him [MEDICATION NAME]. She said the facility told her they would discontinue the medication on 12/29/2015, but he continued to receive it. She said her family never gave consent to the antipsychotic medications and said he never had a [DIAGNOSES REDACTED]. In an interview on 3/3/2016 at 11:35am, the DON said she reviewed resident ' s antipsychotic medication if they were admitted with them or if they were newly prescribed. She said she would ensure the resident had an appropriate [DIAGNOSES REDACTED]. She said she was not sure what CR #1 ' s [MEDICATION NAME] or [MEDICATION NAME] was used for, and said she would find out. In an interview on 3/3/2016 at 12:35pm, the DON said CR #1 ' s consent for the [MEDICATION NAME] medication was in the nurse notes. (Record review of the nurse notes revealed there was no consent documented for [MEDICATION NAME]). She further stated that CR #1 was prescribed [MEDICATION NAME] and [MEDICATION NAME] for a [DIAGNOSES REDACTED]. In a telephone interview on 3/3/2016 at 3:15pm, LVN N said she cared for CR #1. She said before he fell , he was ambulatory and mildly confused. She said when he returned to the facility from the hospital after the fall, he was more confused, agitated and restless. She said he would not stay still. She said she worked the night shift, and CR #1 did not sleep well at night. She said it was dangerous for him to walk around because she was the only nurse on the unit. She said he would talk to himself, take off his clothing, and would try to stand up from his wheelchair. She said she would give him [MEDICATION NAME] if he was agitated or exhibiting the above behaviors. Resident #9 Record review of Resident #9's face sheet revealed Resident #9 was [AGE] years old. She was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's Admission assessment MDS dated [DATE] revealed Resident #9 had moderate cognitive impairment and had inattention. Further record review revealed that she did not have sign and symptoms of [MEDICAL CONDITION] or behaviors. Resident #9 required extensive assistance for bed mobility, dressing, personal hygiene and bathing and required total assistance from staff for toilet use. She was always incontinent of bowel and had an Indwelling catheter. Record review of Resident #9's Physician's Orders revealed the following: - [MEDICATION NAME] XR tablet extended release 24 hours 50 mg, give 2 tablets by mouth at bedtime for [MEDICAL CONDITION] dated 1/27/2016. Further record review of Physician's orders revealed no orders to monitor for side effects for [MEDICATION NAME] XR or to monitor any behaviors. Record review of Resident #9's MAR indicated [REDACTED]. Further record review revealed no monitoring for side effects or behaviors. Record review of Resident #9's medical record revealed that there were no consents for [MEDICATION NAME] XR tablet extended release 24 hours 50 mg, give 2 tablets by mouth at bedtime for [MEDICAL CONDITION].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455876**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/03/2016**
NAME OF PROVIDER OF SUPPLIER **THE WOODLANDS HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **4650 S PANTHER CREEK DR** **THE WOODLANDS, TX 77381**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) In an observation and interview on 3/3/2016 at 1:27 p.m. with ADON C, she stated that consents for antipsychotic medications were located in the consent section of the chart. Further interview and observation revealed that ADON C flipped thru Resident #9 ' s chart and said I have to look at the entire chart. We are on the process of updating the charts . Continued interview and observation revealed that ADON C was not able to find a consent on Resident #9 ' s chart and said We need to get one . ADON C further said for behavior monitoring and side effects, the nurses would documents on the nurses notes if they see a side effect or a behavior, if it is not documented, it means they did not see anything . In an observation and interview on 3/3/2016 at 1:41 p.m. with the DON, she stated that consents were supposed to be on the chart. Further interview and observation, the DON flipped thru Resident #9 ' s chart at that moment and said I don't see them. In an interview on 3/3/2016 at 2:13 p.m. with ADON C, she stated that she had just spoken to Resident #9 ' s family member and had obtained verbal consent for [MEDICATION NAME] medication. In an interview with the DON on 3/3/2016 at 2:46 p.m. she stated that the facility did not have in place the behavior monitoring for the [MEDICAL CONDITION] medications or monitoring of side effects and that the facility was currently working to getting particular behaviors monitoring and side effects in place. Record review of an In-Service dated 2/25/2016 revealed that nursing staff were being educated regarding behavior monitoring as part of a quality assurance initiative. Issue: Behavior monitoring not being recorded for use of [MEDICAL CONDITION] medication. The completion date of the behavior monitoring plan of correction was 3/10/2016. Record review of a facility undated document titled ' Psychotherapeutic Medications Commonly Used in Long Term Care ' revealed the max daily dose for [MEDICATION NAME] was 2mg, and the max daily dose for [MEDICATION NAME] was 2mg. [MEDICATION NAME] was indicated as having an increased mortality risk in elderly residents with dementia, and was not recommended for use in patients who have dementia. It further revealed staff were to monitor for side effects such as .dry mouth, constipation . falls lethargy, sedation. Record review of the facility policy for Psychotherapeutic Medication Use dated 1/1/2014 read in part . The Center identifies factors (e.g., environmental and psychosocial stressors, treatable medication conditions, etc.) that contribute to or are responsible for changes in the patient ' s behavior. Whenever possible and clinically appropriate, Center staff will recommend non-drug approaches such as behavioral interventions, environmental modifications, or alternative approaches to care to assist in the treatment or modification of the patient ' s behavior . Purpose: To ensure patients are prescribed psychotherapeutic drugs for appropriate indications, dosages, length of treatment and duration. To encourage the use of non-pharmacologic interventions prior to the use of psychotherapeutic drug interventions .Center staff monitor the patient ' s behavior using a behavioral monitoring chart or behavioral assessment record for patients receiving psychotherapeutic medications for organic mental syndrome with agitated or psychotic behaviors. According to the CMS Form 672, there were 35 resident receiving antipsychotic medications.