STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676314	A. BUILDING _____ B. WING _____	**07/12/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LA HACIENDA NURSING & REHAB CENTER	**3730 W. OREM DRIVE HOUSTON, TX 77045**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314 **Level of harm -** 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 demonstrate that they were unavoidable and a resident having pressure sores receives necessary treatment and services to promote healing for 1 of 6 residents (Residents #2) reviewed for pressure sores in that; -Resident # 2 developed a facility acquired unstageable pressure sore to his sacrum which became infected. These failures affected 1 resident and placed 9 additional residents who have pressure sores at risk for developing more pressure sores, infection and or worsening of the existing pressure sores. Intake numbers: 8 Findings include: Resident #2 Record review of Resident # 2's admission record revealed he was [AGE] years old and was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident # 2's Admission Minimum Data Set ((MDS) dated [DATE] revealed he had a Brief Interview for Mental Status (BIMS) score of 11 (moderate impairment), no skin issues but at risk of developing pressure ulcer, he required total assistance with 1 to 2 persons support with locomotion on and off unit and eating; he also needed extensive assistance with 1 to 2 persons support for bed mobility, transfer, personal hygiene, toilet use, bathing and dressing. Resident #2 was non-ambulatory and always incontinent of bowel and bladder. Record review of Resident # 2 ' s Plan of Care (POC) revealed he was care planned for having an unstageable wound of his right buttock/sacrum related to immobility, urinary and bowel incontinence initiated on 5/21/16 and activities of daily living self-care performance deficit related to stroke initiated on 6/1/16. Some specific interventions included: --monitor/document/report to MD as needed changes in skin status --use lifting device, draw sheet etc. to reduce friction --see ADL care plan for . for need for assistance for bed mobility, turning and repositioning -- total assist with bed mobility via 2 person -- total assist with transfers via 2 person Observation of Resident #2 on 6/2/16 at 3.40 p.m.in his room revealed him in bed with eyes closed and in no apparent distress. He was neatly dressed and well groomed. Resident ' s room was clean and well-arranged and oxygen in use. Record review of Resident # 2 ' s Admission notes documented by the ANur dated 5/20/16 at 22.31 revealed no skin problem noted. Record review of Resident #2 ' s Situation, Background, Appearance and Review(SBAR) communication form dated 5/17/16 revealed LVN C reported resident had an unstageable pressure ulcer on his sacrum, MD was notified and Wound Care was consulted. physician's orders [REDACTED]. Record review of Resident #2 ' s of medical record revealed that the Initial Wound Evaluation by his wound doctor dated 5/24/15 showed resident had an unstageable necrosis pressure sore to his sacrum measured as follows - Length 10.4 cm, Width 9.6 cm, Depth not measurable cm, thick adherent devitalized necrotic tissue 100%, Surface area 99.84 sq. cm, odor present and exudate - moderate serous. Wound debrided via surgical excision and removed necrotic tissue. Wound Care physician's orders [REDACTED]. Doxycycline 100 mg BID x 14 days.[MEDICATION NAME] mg BID x 10 days. Record review of Resident # 2 ' s laboratory report of wound culture dated 6/4/16 revealed resident had infection (Pseudomonas aeruginosa - moderate growth and Gram-negative rods #2- many colonies noted) to his sacral wound requiring treatment with antibiotics and subsequent transfer to the hospital on [DATE]. Record review of Resident #2 ' s hospital medical record revealed she was admitted to the Emergency Department on 6/7/16 with an unstageable sacral decubitus . Wound Care Consultation notes with assessment/measurement as follows: Stage IV Sacral wound Wound is approximately 95% slough and yellow necrosis There is bone exposure Moderate to large amount of serosanguinous exudate Sacrum stage IV measuring: Length 10.0cm x Width 8.0cm x Depth 1.5cm Wound bed slough, bone palpable, granulating tissue at edges, large amount of serous exudate, edges undefined and undermining 10:00-2:00 @ 1.0cm. During an interview on 6/16/16 at 4:45 p.m. MDS/LVN she said Resident # 2 was admitted to the facility on [DATE] without a pressure sore. She said Resident # 2 was discovered to have a large facility acquired unstageable pressure sore on 05/17/2016. During an interview on 6/16/16 at 5:30 p.m. the DON she said Resident # 2 was discovered to have a large facility acquired unavoidable sacral wound on 05/17/2016. She said Resident # 2 was a huge man (218 pounds) who was not mobile and was incontinent of bowel and bladder. She said Resident # 2's wound was discovered to be infected on 06/04/2016 after the physician had ordered wound cultures. She said Resident # 2 was turned every two hours and he was up out of his bed to the chair daily. During a telephone interview on 6/16/16 at 5:45 p.m. LVN C said that he discovered the wound on 5/17/16 during a weekly skin assessment. He said the wound started like sheering and progressed to an unstageable. He said the physician stages the wounds in the facility. During an interview on 6/30/16 at 12:22 p.m. the DON she said treatment of [REDACTED]. During a second telephone interview on 6/30/16 at 2:38 p.m. LVN C said that a CNA called him to Resident #2 ' s room while they were performing care and notified him of the wound to his sacrum. He said he assessed the wound, called the MD and contacted a family member. During an interview on 6/30/16 at 3:00 p.m. the DON when asked who did wound treatments when WCN was not available during the week, she said that the Unit managers did the treatments. Record review of the facility's policy and procedure on Skin Management system revised on 3/2016 read in part a head to toe body evaluation will be completed on every resident up admission or readmission and weekly thereafter, these evaluations will be documented on the Weekly Skin Integrity Review . responsible party will be notified at the onset of an identified

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 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) area, documentation of the notification is to be in the Nurses notes in the clinical record .routine weekly checks will be completed on every resident, if a new pressure sore is noted, a Ulcer, Surgical Site treatment and Progress Record form will be started, notification of Physician and RP must be documented in the nurses notes, Braden Scale will be completed upon admission, admission/readmission, weekly x3 weeks, change in condition and then quarter thereafter on the Braden Scale form . The CMS Form 672 listed 11 residents as having pressure ulcers.