| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455429 | A. BUILDING _____ B. WING _____ | 03/12/2017 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| COLONIAL TYLER CARE CENTER | 930 S BAXTER TYLER, TX 75701 |

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 0309<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide necessary care and services to maintain the highest well being of each resident**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to maintain the highest well-being in accordance with the comprehensive assessment and plan of care for 1 of 2 residents reviewed for quality of care. (Resident #2)<br>The facility did not provide treatment for [REDACTED].<br>This failure could place 3 residents with non-pressure related wounds at risk for infection or other complications.<br>Findings included:<br>Physician orders [REDACTED].#2 was [AGE] years old and admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #2 was to receive wound care to his abdominal wound twice a day.<br>An MDS dated [DATE] indicated Resident #2 understood others and made his needs known. He was dependent on staff with bed mobility, dressing, and toilet use. He required extensive assistance with transfers and personal hygiene. He had a [MEDICAL CONDITION] bag and urinary catheter.<br>A care plan dated 02/13/17 indicated Resident #2 had skin breakdown to his abdomen. The interventions included evaluating the wound area daily including the surrounding tissue and providing daily wound care.<br>The most recent wound assessment dated [DATE] indicated Resident #2's abdominal wound measured 1.5 cm x 2.0 cm x 0.4 cm. The assessment indicated Resident #2's abdominal wound was from a percutaneous endoscopic gastrostomy (peg tube) removal. and was not staged (a tube passed into a patient's stomach through the abdominal wall)<br>A TAR for March 2017 indicated Resident #2 received wound care to his abdomen on 03/11/17 and 03/12/17.<br>During an interview on 03/12/17 at 11:29 a.m., LVN B said she was the charge nurse for Resident #2. She said she had not performed wound care on Resident #2 today (03/12/17) because she did not have time yet. and she would not perform wound care until after 2:00 p.m. She said the treatment nurse was only worked provided wound care Monday through Friday and the charge nurse provided it on the weekends.<br>During an interview on 03/12/17 at 1:48 p.m., Resident #2 said staff had not performed wound care on any of his wounds since Friday (03/10/17).<br>During an observation on 03/12/17 at 3:31 p.m., Resident #2's dressing on his abdomen was dated 03/10/17. LVN B removed the old dressing and measured the wound. The open area of the wound was reddish pink with a scant amount of drainage. The wound area of Resident #2's abdominal wound measured 0.4 cm x 0.6 cm.<br>During an interview on 03/12/17 at 5:11 p.m., LVN C said she worked 03/11/17 and documented that she performed wound care on Resident #2, but did not actually do the treatment.<br>During an interview on 03/12/17 at 5:22 p.m., LVN B said she documented that she performed wound care on Resident #2 on 03/12/17 prior to performing his wound care; however, she did not do it She said she did not have enough time to do the treatment.<br>During an interview on 03/12/17 at 5:30 p.m., the DON said Resident #2's wound care should have been provided daily.<br>The skin integrity management policy with a revised date of 11/28/16 indicated:<br>.Perform skin inspection upon admission/readmission and weekly .<br>.Perform daily monitoring of wounds or dressings for presence of complications or declines and document .<br>The wound care log dated 03/12/17 indicated 3 residents had non-pressure injuries. |
| F 0314<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Some | **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure necessary treatment and services were provided based on the comprehensive assessment to promote healing and prevent new injuries from developing for 1 of 2 residents reviewed for pressure injuries. (Resident #2)<br>The facility did not provide treatments for Resident #2's stage 4 pressure injuries on his left ischium (gluteal fold) and sacrum area for 2 days and did not provide weekly assessments. The pressure injuries worsened in size and had a foul odor. The resident developed a new stage 2 pressure injury on his right ischium (gluteal fold).<br>This failure could place 7 residents who had pressure injuries at risk for worsening of existing pressure injuries and developing new pressure injuries.<br>Findings included:<br>Physician orders [REDACTED].#2 was [AGE] years old and admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #2 had orders<br>for daily wound care to his sacrum (area above tailbone) and left ischium wounds (gluteal fold).<br>An MDS dated [DATE] indicated Resident #2 understood others and made his needs known. He was dependent on staff with bed mobility, dressing, and toilet use. He required extensive assistance with transfers and personal hygiene. He had a [MEDICAL CONDITION] bag and urinary catheter. The MDS indicated Resident #2 was at risk for developing pressure injuries and Resident #2 was admitted with pressure injuries.<br>A care plan dated 02/13/17 indicated Resident #2 had skin breakdown to his abdomen, left ischium, and sacrum. Interventions included evaluating the wound area daily including the surrounding tissue and providing daily wound care.<br>The most recent pressure injury assessment dated [DATE] indicated Resident #2's left ischium wound was a stage 4 and measured 4.0 cm x 4.0 cm x 4.6 cm.<br>The most recent pressure injury assessment dated [DATE] indicated Resident #2's sacral wound was a stage 4 and measured 3.8 cm x 3.8 cm x 10.2 cm.<br>During an interview on 03/12/17 at 11:29 a.m., LVN B said she was the charge nurse for Resident #2. She said she had not performed wound care on Resident #2 today (03/12/17) because she did not have time yet. She said the treatment nurse provided treatments Monday through Friday and the charge nurses provided the treatments on the weekends. She said the treatment nurse was responsible for weekly skin assessments.<br>During an interview on 03/12/17 at 1:48 p.m., Resident #2 said staff had not performed wound care on his 2 pressure injuries since Friday (03/10/17).<br>During an observation on 03/12/17 at 3:31 p.m., Resident #2's dressings on his sacrum and left ischium pressure injuries were dated 03/10/17. LVN B removed the soiled, yellow stained dressings that smelled of infection. LVN B removed the soiled packing from Resident #2's sacrum and left ischium wound beds. The packing was stained brownish red and smelled of rotten flesh. Resident #2 said his wounds smelled bad because his dressings were not changed for 2 days. Resident #2's stage 4 |

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<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>left ischium pressure injury wound bed was bright red and measured 5 cm x 3.1 cm x 5 cm. Resident #2's stage 4 sacral wound bed was bright red and measured 3.5 cm x 5.8 cm x 9.2 cm. Resident #2 had an undocumented new pressure injury on his right ischium (gluteal fold) that was covered by the old bandage. The right ischium stage 2 pressure injury was red in color and measured 0.7 cm by 0.3 cm.<br>During an interview on 03/12/17 at 5:11 p.m., LVN C said she worked 03/11/17 and documented that she performed wound care on Resident #2, but did not actually do the treatment.<br>During an interview on 03/12/17 at 5:22 p.m., LVN B said she documented that she performed wound care on Resident #2 prior to performing his wound care. She said she did not have enough time to do the treatment for [REDACTED].<br>During an interview on 03/12/17 at 5:30 p.m., the DON said Resident #2's wound care should have been provided daily.<br>The skin integrity management policy with a revised date of 11/28/16 indicated:<br>.Perform skin inspection upon admission/readmission and weekly .<br>.Perform daily monitoring of wounds or dressings for presence of complications or declines and document .<br>.For wounds requiring daily dressing changes or wounds without a dressing, monitor for signs of decline in wound status .<br>The National Pressure Ulcer Advisory Panel (NPUAP) website,<br>http://www.npuap.org/resources/educational-and-clinical-resources, indicated the following:<br>Pressure Injury:<br>A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.<br>.Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis<br>Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel .<br>.Stage 4 Pressure Injury: Full-thickness skin and tissue loss<br>Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury .<br>The CMS 672 dated 03/12/17 indicated 7 residents had pressure injuries. |