STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	**08/22/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	**7514 KINGSLEY ST HOUSTON, TX 77087**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** 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 a significant change in condition occurred for 2 of 18 residents (CR#1 and #15) reviewed for physician consultation in that: --CR#1 complained of pain to his private area on [DATE] and the facility failed to consult with his physician. On [DATE] he was discharged to a local hospital for respiratory issues. He had a severe cut from the top of the penis along the shaft and down to the bottom of his penis with an open wound around the shaft. --Resident #15 had a significant change in condition at approximately 9.00 am - 9:30 am on [DATE] and was not monitored for approximately two hours. His physician was not notified of resident's condition and he received no reassessment. He later died in the hospital. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility needed additional time to monitor and evaluate the effectiveness of their plan. These failures affected 1 hospitalized and 1 current resident and placed 11 additional residents in the facility with an indwelling catheter at risk of injury, harm, delayed medical treatment intervention, and possible hospitalization or death. Intake # 7 and # 2 Findings include: Closed Record #1 Record review of CR #1's admission record revealed he was [AGE] years old and was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. He was discharged to the hospital on [DATE]. Record review of CR #1's Admission Nurse's notes by LVN U dated [DATE] revealed CR #1 was incontinent of bowel and bladder and there was no documentation of the presence of an indwelling urinary catheter. No other nurses' notes showed he had an indwelling catheter or that the catheter was changed through the time he was discharged . Record review of CR # 1's Admission Clinical Health Status note dated [DATE] documented his elimination and skin condition as follows: --Bladder: Incontinent. There was no documentation of him having an indwelling urinary catheter. The notes documented he was assessed as, incontinent of bowel and bladder. Record review of CR #1's Admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 5 indicating he had severely impaired cognition. He required extensive assistance for dressing, toilet use, and personal hygiene. He required total care with bathing. CR #1 needed supervision for eating and [DIAGNOSES REDACTED]. The MDS did not note the presence of his indwelling urinary catheter. His skin assessment revealed no pressure ulcer but that the resident was at risk of developing pressure ulcers. Record review of CR #1's Discharge MDS assessment dated [DATE] revealed no BIMS score documented. He required extensive assistance for dressing, toilet use, personal hygiene, and total care with bathing. CR #1 needed limited assistance for eating. Assessment of bowel and bladder revealed he was always incontinent of bowel and frequently incontinent of bladder. No skin assessment documented. Record review of Resident # 1's Care Plan for Activities of daily living (ADL) , not dated and not signed, had conflicting interventions. The intervention for bladder function revealed staff to assist resident as needed and record each shift whether he had voided. The same care plan had another intervention that stated resident had urinary catheter and directed staff to provide catheter care and record output. Record review of CR #1's unsigned physician's orders [REDACTED]. There were no admission orders [REDACTED] Record review of CR #1's Medication Admission Record dated July and [DATE] revealed no documented schedule or care for his indwelling urinary catheter. Record review of CR #1's Progress Notes for the month of [DATE] documented by the Nurse Practitioner (NP) for the Therapy department revealed as follows: --[DATE]: He was also complaining about pain in his 'privates.' --[DATE]: He wanted to know who was taking care of his privates now and he was told that the PCP (Primary Care Physician) at Afton was in charge. I discussed his problem with the ADON and she will talk to the patient about his concerns. He stated that other than his pain in his privates he felt ok. --[DATE]: The patient was still complaining about not understanding why he has a problem with his 'privates'. Per nursing, he only seems to complain about the catheter when I am present. Record review of CR#1's clinical record revealed no documentation of follow up care or physician notification. During an interview on [DATE] at 3:23 p.m. with the House Supervisor at the local hospital, she said her concern was that upon admission, CR #1's Foley catheter was dirty, his penis was filleted, it was open and he (Resident # 1) was septic. Record review of CR #1's medical records from the the local hospital obtained on [DATE] revealed he was admitted to the emergency room of the hospital on [DATE] at 13:22 p.m. and upon nursing assessment, it was noted, .Foley in place extremely dirty with sediments all along tube walls, patient's penis is split open from the bottom along the shaft. Urine dark brown It was also documented that CR #1 had [MEDICAL CONDITION] +2 to Right upper arm, right elbow, right forearm, left midcalf, left ankle, left upper arm, left elbow, left forearm, right midcalf and right ankle. Record review of the Physician's Progress Notes from the local hospital dated [DATE] at 9:55 p.m. revealed assessment and plan as follows: --Sepsis secondary to healthcare-associated pneumonia and urinary tract infection secondary to [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) and [MEDICATION NAME]. Urologist consult report from the local hospital dated [DATE] revealed as follows: --the patient noted on a thorough exam by ICU to have an indwelling Foley catheter for unknown reasons and found to have significant traumatic [DIAGNOSES REDACTED] from the Foley catheter. --the patient was previously admitted in the hospital in July and was discharged after a two-week stay to nursing home with a Foley catheter --Foley catheter presumed to be in place for likely [MEDICAL CONDITION] and there was no records found to document whether Foley catheter has been changed or not at the nursing home. The Urologist assessment revealed that the indwelling catheter was in place with approximately 5 cm of traumatic [DIAGNOSES REDACTED] and ventral erosion likely from Foley catheter and stated that the patient needs the Foley catheter to be

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) exchanged and that he could benefit from a suprapubic tube in the future if he desires. Additionally, Nurses Shift Goals- Integumentary from the local hospital documented on [DATE] at 7:00 a.m. noted penile shaft open wound approx. ,[DATE] inch long, monitor s/sx (signs/symptoms) of infection. Observation and interview of CR #1 in his room at the local hospital on [DATE] at 10:59 a.m. with the hospital nurse and social worker present revealed he was alert and oriented to person and place. His right hand was swollen. He answered questions appropriately and coherently. CR #1 said, I will be [AGE] years old and never had something like this happen like this, someone cut it-someone cut it completely open down the shaft . He added the service he received at Afton Oaks was not good. He said, It looks like someone didn't like me, for some reason but I hadn't did anything to anyone, I don't want to go back there, my family member will take me home to (name of home State). CR #1 was in Isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his hospital nurse, she said it did not look like his catheter had been taken care of. She said there were old wounds to the front and lateral shaft. She said there was a large laceration on his penis draining pus and the meatus was sliced open, not healed, and with a pink bed to it. Observation of CR #1 in his room at the Medical Center on [DATE] at 8:15 a.m. revealed he was alert and oriented to person and place. His skin was dry with mild swelling to his extremities. He answered questions appropriately and coherently. CR #1 said he was butchered and sore. CR #1 remained on isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his nurse, it was noted that he had a severe cut from the tip of the penis along the shaft and down to the bottom of his penis with an open wound around the shaft and about 80% granulation tissue and 20% slough. He had no Pressure ulcer. CR #1 was still being treated with intravenous and oral antibiotics. The hospital nurse said they were treating the wound with wet to dry dressing changes. During an interview on [DATE] at 4:40 p.m., the Director of Nursing said that CR #1 was admitted into the facility with an indwelling catheter on [DATE]. When asked why his admission MDS assessment did not show documentation of the catheter, she said that she did not know. When asked about CR #1's wound assessment, the DON said his pressure ulcer was a stage 2 on his sacrum. She said that she did the resident's admission skin assessment in the presence of two other staff and that the wound was a stage 2 and it healed within three days. During an interview on [DATE] at 5:24 p.m. with CNA 57 in regards to CR #1 she was asked did she ever provide care for him and she answered, I don't remember, never took care of him. During an interview on [DATE] at 5:45 p.m., the DON said CR #1 was admitted from hospital with the catheter and that it was placed on [DATE] at the hospital. She also said the resident had the catheter placed due to [MEDICAL CONDITION] and [MEDICAL CONDITION] bladder. During an interview on [DATE] at 10:13 a.m. with LVN CE, she said in regards to CR #1 he used to sing and everything while doing his care. His right arm was swollen when he came. She said she would help the Treatment Nurse turn him. She said he had a Foley catheter. She said she knew she had taken care of him through the week but could not remember the day. She said his hand was hurting and she gave him a [MEDICATION NAME] and breathing treatment. She said he was sitting up in a chair. She said she could remember that when you got him out of bed, all he wanted to do was go back to bed and he liked to talk. During an interview on [DATE] at 11:00 a.m., the Treatment Nurse (RN AB) said CR #1 had intermittent confusion, his bottom and scrotum were intact. He had a Foley catheter. During an interview on [DATE] at 11:43 a.m. with CNA 31, she said she remembered CR #1. She said she was out for about 6 weeks and returned on the 7th of August. She said CR #1 was a real nice gentleman. She said he started going to the dining room, was taking therapy, and she would give him his showers on Monday, Wednesday and Friday. She said there were no concerns for him. She said he had a little red area on his buttocks and she documented it on the shower sheet and in a couple of days the red area was gone. She said he was incontinent of both bowel and bladder, no Foley or ostomy, but could not really remember. During an interview on [DATE] at 11:51 a.m. with CNA 44, she said that CR #1 was nice, sweet, and that she helped him with everything, he asked, showers, and assist to chair. She said he was incontinent of bowel and bladder and had a urinary catheter. She said there were no problems or skin issues. During an interview on [DATE] at 12:00 p.m., the ADON when asked what she knew about CR #1, she said he was admitted during the middle of July, had an indwelling catheter, and [MEDICAL CONDITIONS] with [MEDICAL CONDITION]. She said the resident was cognitively confused intermittently and complained of pain to the Right shoulder. When asked whether she had any discussion with CR #1's Physician or NP's recently she said not that she could .remember or think of. When asked whether she had discussed with the Nurse Practitioner (NP) with the therapy department she said that Nurse Practitioner (NP) on one occasion said to her in a joking manner something about the resident's catheter and that he, CR #1, said he was going to call an Attorney. She said she did not know what the complaint was about and that it took place about 3 weeks prior. She also said she asked the nurses if CR #1 had complained to them about his catheter and they said no. When asked whether he was being given showers she said she had seen staff take him for showers. A request was made to review the resident's shower sheets from admission to his discharge. When asked if the NP discussed with her the Resident's complaint of pain of his privates she said she never discussed anything about that with her. She also said the resident had never complained to her or the staff about pain to his private area or with the catheter. When asked if she assessed the resident's catheter when the NP notified her of resident's complaints about his catheter, she said that she looked at the drainage bag and tubing and it was clean and she did not check the catheter or his penis because he was sitting in his chair. She said if the NP had told her about pain in the resident's private area she would have assessed the area and would have notified the DON and resident's Physician. During a telephone interview on [DATE] at 12:06 p.m., CNA 16 said that she worked at the facility PRN (as needed) and that she had taken care of CR #1. She said that he had a Foley catheter and sores in his private area, looks like he has a cut down there. When asked if she notified her nurse, she said she did not notify the nurse because the sores and cut looked like they had been there for a long time. She said she would have thought the nurses should have known and that as a PRN staff she had not worked since the last few weeks. She said that while cleaning him she had to be careful because it hurt him. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 16 took care of him on [DATE], [DATE], [DATE], [DATE] and [DATE]. Resident was sent to the hospital on [DATE]. Additionally, record review of the Catheter Output Roster revealed that from [DATE] (admitted) to [DATE] (discharge date) staff were documenting that Catheter care was provided each day as follows: [DATE] - 1 time [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 4 times [DATE] - 2 times [DATE] - 1 time [DATE] - 5 times [DATE] - 2 times [DATE] - 3 times [DATE] - 4 times [DATE] - 3 times

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 1 time [DATE] - 5 times [DATE] - 3 times [DATE] - 2 times No documentation from any staff reporting of CR #1 having wound to his penis and sediments in his urine. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 57 signed indicating she provided care for CR #1 on the following days: [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. During an interview on [DATE] at 2:47 p.m. with CNA 57, she was asked about caring for CR #1 again and was shown his picture from his medical record and where she had documented care, including Foley catheter care. She said she recalled care provided saying she never took care of his catheter but could remember feeding him. When asked why did she sign that all care was provided on her on behalf, she replied, that she went around asking other CNA's about their residents things like output and care and entered the information in the kiosk for them in order to keep it from going into red. She said she would go ask the CNA's how much a resident ate and would go report to the nurse if there was a change in condition. She said no one ever told her about a problem with CR #1's catheter or penis but if they did, they were supposed to report it to the nurse. During an interview on [DATE] at 12:50 p.m., the DON she said CR #1 was admitted to the facility with an indwelling catheter but could not remember whether it was changed or not and that best practice should be to document date /time when catheter/bag/ tubing was changed. She also said she did not receive any report and did not hear that he was complaining of pain in his private area. The DON said the implications of not assessing a resident's catheter could be possible retention of urine, and swelling in his pubic area and penis. When asked if staff doing catheter or incontinent care would have seen it if the resident had swelling, sores, and cuts, she said yes, they should have noticed that but if they did not report it nobody would know. Record review of CR #1's shower sheet for [DATE] and [DATE] revealed no documentation of any abnormal finding or wound to the resident's penis. There were no shower sheets for the other days from [DATE] to [DATE]. During a telephone interview on [DATE] at 3:50 p.m. with Physician A, he said he did not receive any calls from the facility regarding sores/cuts or wound on CR #1's penis and he was not notified about his having sediment in his urine. During an interview on [DATE] at 11:55 a.m., the NP for the therapy department said CR #1 had complained to her a couple of times that he was having pain in his privates anytime he saw her and he explained to her that the pain could be from his catheter. The NP said she checked with the nurses and they said he did not complain to them about pain in his catheter or his private area. She also said she had a discussion with the ADON regarding the resident's complaint of pain to his privates and asked for her to look into it and follow up with his Physician. When asked what she would usually do if she had any issues or complaints from any resident, she said she would notify nursing and if the resident's Physician was available, she would mention it to them. She said it was not in her role to assess resident's privates/penis but to notify nursing and she was not sure if he had any problem with his privates or that it was emergent and did not convey it to the ADON as if it was emergent. When asked when she started seeing CR #1, she said from [DATE] to [DATE]. During an interview on [DATE] at 11:25 a.m., the DON when asked whether a staff should document care another person performed, she said that catheter care was done by CNA's and nurses performed care of Suprapubic catheters. She said that whoever did the care should document it and that a CNA should not document care performed by another CNA. Resident #15 Record review of Resident #15's Admission record revealed he was [AGE] years old and was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #15's Admission MDS assessment dated [DATE] revealed he was assessed as having a BIMS score of 11 indicating moderately impaired cognition. He was totally dependent on staff for transfers, dressing, eating, toilet use, personal hygiene, and bathing. He needed the extensive assistance of staff with bed mobility. Record review of Resident #15's plan of care dated [DATE] revealed a plan of care for being at risk for complications related to Cardiac Pace Maker in place, at risk for impaired cardiovascular functions, staff assistance for all ADL's, full code, difficulty recalling recent events and use of indwelling suprapubic catheter due to [MEDICAL CONDITION] bladder and at risk for developing Urinary Tract Infections. Record review of Resident #15's Nurses notes for [DATE] revealed documentation of vital signs/status of resident (per nursing - time reflected was when nurses documented the vitals and not necessarily when the vitals were taken) as follows: --[DATE] at 6:25 a.m. - RN AA documented Resident #15's Temperature 100.5 degrees Fahrenheit, axillary. MD notified, STAT labs and Chest X-ray ordered. --[DATE] at 11:03 a.m. - LVN/Unit Manager (UM) documented that Chest X-ray result revealed left lower lobe increased opacity with consideration for pneumonia, atelectasis and pleural effusion. Notified attending Physician and awaiting response. --[DATE] at 11:21 a.m. - RN AD documented for vital signs taken at 9:00 a:m (per interview with RN AD on [DATE] at 12:20 p.m.): O2 Saturation (SAT) 82% on Room Air (RA), Respiration (Resp) 20, Pulse(P) 123 bpm; resident was put on Oxygen (O2) at 2 liters and Blood Pressure (BP) ,[DATE] mmHg; Physician/Responsible Party (RP) notified. --[DATE] at 11:30 a.m. - RN AD documented she noted the Suprapubic catheter was draining scant urine, MD notified with order to replace catheter, consent obtained from responsible party. --[DATE] at 1:17 p.m. - LVN M documented Resident was difficult to arouse upon verbal and tactile stimuli upon arrival of a visitor. Resp. (respirations) 14 bpm (breathes per minute) , BP (blood pressure) ,[DATE], P (pulse) 62 and no temp. (temperature) and no 02 SAT (oxygen saturation). --[DATE] at 1:32 p.m. - LVN M documented temp. 99 temporal, MD notified and ordered to send Resident #1 out to VA hospital. Contracted Ambulance Response notified at 1:00 p.m. --[DATE] at 2:15 p.m. - LVN M documented - Non rebreather mask applied to resident with O2 (Oxygen) at 15 liters, resident remains stable at this time, 911 arrived at 2:10 p.m., report given, resident still breathing. --[DATE] at 3:00 p.m. - LVN M documented - Addendum: Contracted transport ambulance refused to transport resident due to their assessment of resident which resulted in 911 being called. --[DATE] at 3:31 p.m. - LVN/UM documented a late entry for 2:20 p.m. - 911 in room performing Cardiopulmonary Resuscitation (CPR) on resident starting approximately 2:15 p.m. and [MEDICATION NAME] 15 minutes. Resident left via stretcher escorted by 911 staff. Family members at bedside, attending physician updated. During an interview with Physician #2 on [DATE] at 3:15 p.m. he said that initially he was called about Resident #15 and was told that the resident was not doing well and he ordered some blood work, urine test and chest x-ray. He said he received another call notifying him of the chest x-ray results and that they had not received the results of other blood work. The Physician initially said he believed the staff did what they were supposed to do. He said he talked to the staff at the hospital and they said the resident basically coded. He also said when he spoke with the Medical Examiner he told him he did not need an autopsy and that the body had been released to the funeral home. When asked to explain further, he said that Medical examiners look for wrong doing for an autopsy to be done. When asked if he left any parameters or guidelines as to when to be called he said no and that it was easier to just call him when they have any issues. When asked of the Physician if the facility notified him when Resident #15's O2 SAT dropped to 82% in the morning; when they could not get O2 SAT on him later that morning; when his BP dropped to ,[DATE] and when he became difficult to arouse upon verbal and tactile stimuli, he said he was not notified of those findings and did not know about the situation. When asked what he would have expected the facility to do in those situations, he said he would expect staff to call him immediately. During a confidential interview the person said that they were concerned about the amount of time it took for Resident #15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) to receive medical attention including transporting the resident to the hospital. This person raised concerns about the facility in that they failed to call 911 earlier and felt that Resident #15 would still be alive if medical attention needed and transport by 911 were contacted. They said there was confusion during his time of need. He stayed at the facility for two hours instead of being transferred properly. During an interview on [DATE] at 1:45 p.m., LVN M said she was the desk nurse on the date of the incident, [DATE] and that as the desk nurse she was responsible for charting skin assessments, weekly notes, antibiotic charting, and getting paper work ready for resident appointments amongst other tasks. She said she knew what was happening when a visitor came to the desk and said she was Resident #15's visitor and his condition was not good and wanted to know what was happening. She also said RN AD was the floor nurse that had the resident. She further said she went to the room with RN AD to assess the resident and did vital signs on him as follows: BP ,[DATE], P 62, and Resp. ,[DATE] and could not get O2 reading. She said the resident did not respond to his name. She said RN AD left the room and came back and told her the resident was going to be sent out. At about 1:30 p.m. LVN M wrote the transfer order, and prepared transfer papers. She said she did not know what time the transportation was called but noted transport arrived about 1:50 p.m. She said that when transport arrived, they came to the desk and told her they could not transport Resident #15 because they did not have the proper equipment. She called the DON and she said to call 911. When 911 staff came most of the staff went to the room. She said she documented what she was asked to write by LVN/UM. When asked what she should do when a resident had a change in condition, she said assess the resident, obtain vital signs, call the MD, notify DON/RP, and follow MD orders. She said if a resident's condition became worse she would call 911 and notify the MD. LVN M was able to enumerate what to do when she got a new admission including assessment of skin and indwelling catheter - when it was inserted and how urine looks. She said she should get physician's orders [REDACTED]. During an interview on [DATE] at 3:30 p.m., LVN/UM said she was made aware by RN AD that Resident #15 had a temperature of 100.5 degrees Fahrenheit and she gave him Tylenol. She said they document vital signs on their nurse's notes and some on the Medication Administration Record [REDACTED]. She said she was on another hall when she learned about the resident's condition and on getting to the room [ROOM NUMBER] was already there doing CPR. She said the DON with other nurses were in the room. She said she knew the MD was notified of X-ray results but not when his O2 SAT dropped/vital signs. When asked what staff should do when a resident had a change in condition, said they should assess resident including getting vital signs and O2 SAT, call MD and RP and carry out MD orders. She also said others should be documented in the nurse's notes and on their SBAR. She said nurses should not administer medications/treatments without a physician's orders [REDACTED]. During an interview on [DATE] at 5:12 p.m., the DON when asked whether she knew Resident #15 had a change in condition and what happened, she said she knew he had a change in condition and was going to the hospital. She then said she received a call from the nurse that the transport company refused to transport Resident #15 because they could not get an O2 SAT reading on him. She said 911 was already called. She said when she got to the room the resident was still breathing, 911 staff came, checked and obtained his pulse, and then started bagging him and putting in an IV catheter. When the 911 staff came into the room, they intubated him and started CPR. She further said they worked on him for a while before taking him to the ER. When asked whether they should have called 911 instead of the ambulance transport service they use she said the staff had called the ambulance transport service because the resident was clinically stable. She also said when his O2 SAT dropped to 82% Oxygen was applied and he was always having high heart rate even on admission. She said she did not know staff could not get his O2 SAT at 1:17 p.m. as per the nurse's notes and did not know if vital signs were done between the hours of 11:21 a.m. and 1:17 p.m. She said there were many people in the room and thought vital signs were done during that time frame. Requested documentation of the vital signs/monitoring of the resident during the time frame, none was provided provided prior to exit on [DATE]. When the DON was asked if she conducted an investigation regarding the incident, she said yes and she felt anything that needed to be done was done. Surveyor requested for the investigation report. The DON left the room and returned about 10 minutes later and said she did not write the report unless the surveyor wanted her to go and write one then. During a telephone interview on [DATE] at 12:20 p.m., RN AD acknowledged she had Resident #15 on the day shift on [DATE]. She said that when she made rounds that resident was talking and carried on conversation. She said she took the resident's vital signs between 9:00 a.m. and 9:30 a.m. and his O2 SAT was low. She said she notified her supervisor - LVN/UM, put him on O2 at 2 liters and notified Physician #2. She said resident had a temperature and was given Tylenol and Physician #2 was also notified and he ordered Stat laboratory tests, urine tests and x-ray which were performed. When asked why the resident was not monitored including checking his vital signs between when she checked him in the morning at 9:00 or 9:30 a.m. and 1:17 p.m. when the resident's guest notified the desk nurse that the resident was not responding, she said she did vital signs on the resident but did not know the desk nurse did not document the vital signs. She said that after she started Resident #15 on O2, she rechecked his O2 SAT but did not document it and said she remembered mentioning it to somebody but could not remember who at this time. She also said that the resident was monitored but understands that if it was not documented, it was not done. She acknowledged that LVN M notified her that she could not get an O2 SAT on Resident #15 and that was when they decided to send him out. When asked why she did not notify the resident's Physician of the O2 SAT of 82% at about 9:00 a.m., inability to obtain O2 SAT, P 62, Resp. 14 bpm and resident being difficult to arouse by verbal or tactile stimuli documented at 1:17 p.m., she said she thought LVN/UM did. Record review of the contracted Ambulance Transport Run Report Sheet dated [DATE](TRUNCATED)
F 0224 **Level of harm** - Immediate jeopardy **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 observation, interview, and record review the facility failed to implement policies and procedures that prohibit neglect for 2 of 18 residents (CR#1 and Resident #15) reviewed for neglect in that: --The facility failed to ensure CR #1 had physician orders [REDACTED]. --The facility failed to arrange timely emergency transportation on [DATE] at approximately 9:,[DATE]:30 a.m. for Resident #15 when his oxygen saturation dropped to 82%. 911 was not called until 1:00 p.m., approximately 4 hours later. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility needed additional time to monitor and evaluate the effectiveness of their plan. These failures affected CR #1 and 1 current resident and placed 11 additional residents in the facility with an indwelling catheter at risk of injury, harm, delayed medical treatment intervention, and possible hospitalization or death. Intake # 7 and # 2 Findings include: Closed Record #1 Record review of CR #1's admission record revealed he was [AGE] years old and was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. He was discharged to the hospital on [DATE]. Record review of CR #1's Admission Nurse's notes by LVN U dated [DATE] revealed CR #1 was incontinent of bowel and bladder and there was no documentation of the presence of an indwelling urinary catheter. No other nurses' notes showed he had an indwelling catheter or that the catheter was changed through the time he was discharged . Record review of CR # 1's Admission Clinical Health Status note dated [DATE] documented his elimination and skin condition as follows: --Bladder: Incontinent. There was no documentation of him having an indwelling urinary catheter. The notes documented he was assessed as, incontinent of bowel and bladder. Record review of CR #1's Admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 5 indicating he had severely impaired cognition. He required extensive assistance for dressing, toilet use, and personal hygiene. He required total care with bathing. CR #1 needed supervision for eating and [DIAGNOSES REDACTED]. The MDS did not note the presence of his indwelling urinary catheter. His skin assessment revealed no pressure ulcer but that the resident was at risk of developing pressure ulcers. Record review of CR #1's Discharge MDS assessment dated [DATE] revealed no BIMS score documented. He required extensive assistance for dressing, toilet use, personal hygiene, and total care with bathing. CR #1 needed limited assistance for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	**08/22/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	**7514 KINGSLEY ST HOUSTON, TX 77087**

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 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) eating. Assessment of bowel and bladder revealed he was always incontinent of bowel and frequently incontinent of bladder. No skin assessment documented. Record review of Resident # 1's Care Plan for Activities of daily living (ADL) , not dated and not signed, had conflicting interventions. The intervention for bladder function revealed staff to assist resident as needed and record each shift whether he had voided. The same care plan had another intervention that stated resident had urinary catheter and directed staff to provide catheter care and record output. Record review of CR #1's unsigned physician's orders [REDACTED]. There were no admission orders [REDACTED] Record review of CR #1's Medication Admission Record dated July and [DATE] revealed no documented schedule or care for his indwelling urinary catheter. Record review of CR #1's Progress Notes for the month of [DATE] documented by the Nurse Practitioner (NP) for the Therapy department revealed as follows: --[DATE]: He was also complaining about pain in his 'privates.' --[DATE]: He wanted to know who was taking care of his privates now and he was told that the PCP (Primary Care Physician) at Afton was in charge. I discussed his problem with the ADON and she will talk to the patient about his concerns. He stated that other than his pain in his privates he felt ok. --[DATE]: The patient was still complaining about not understanding why he has a problem with his 'privates'. Per nursing, he only seems to complain about the catheter when I am present. Record review of CR#1's clinical record revealed no documentation of follow up care or physician notification. During an interview on [DATE] at 3:23 p.m. with the House Supervisor at the local hospital, she said her concern was that upon admission, CR #1's Foley catheter was dirty, his penis was filleted, it was open and he (Resident # 1) was septic. Record review of CR #1's medical records from the the local hospital obtained on [DATE] revealed he was admitted to the emergency room of the hospital on [DATE] at 13:22 p.m. and upon nursing assessment, it was noted, .Foley in place extremely dirty with sediments all along tube walls, patient's penis is split open from the bottom along the shaft. Urine dark brown It was also documented that CR #1 had [MEDICAL CONDITION] +2 to Right upper arm, right elbow, right forearm, left midcalf, left ankle, left upper arm, left elbow, left forearm, right midcalf and right ankle. Record review of the Physician's Progress Notes from the local hospital dated [DATE] at 9:55 p.m. revealed assessment and plan as follows: --Sepsis secondary to healthcare-associated pneumonia and urinary tract infection secondary to [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) and [MEDICATION NAME]. Urologist consult report from the local hospital dated [DATE] revealed as follows: --the patient noted on a thorough exam by ICU to have an indwelling Foley catheter for unknown reasons and found to have significant traumatic [DIAGNOSES REDACTED] from the Foley catheter. --the patient was previously admitted in the hospital in July and was discharged after a two-week stay to nursing home with a Foley catheter --Foley catheter presumed to be in place for likely [MEDICAL CONDITION] and there was no records found to document whether Foley catheter has been changed or not at the nursing home. The Urologist assessment revealed that the indwelling catheter was in place with approximately 5 cm of traumatic [DIAGNOSES REDACTED] and ventral erosion likely from Foley catheter and stated that the patient needs the Foley catheter to be exchanged and that he could benefit from a suprapubic tube in the future if he desires. Additionally, Nurses Shift Goals- Integumentary from the local hospital documented on [DATE] at 7:00 a.m. noted penile shaft open wound approx. ,[DATE] inch long, monitor s/sx (signs/symptoms) of infection. Observation and interview of CR #1 in his room at the local hospital on [DATE] at 10:59 a.m. with the hospital nurse and social worker present revealed he was alert and oriented to person and place. His right hand was swollen. He answered questions appropriately and coherently. CR #1 said, I will be [AGE] years old and never had something like this happen like this, someone cut it-someone cut it completely open down the shaft . He added the service he received at Afton Oaks was not good. He said, It looks like someone didn't like me, for some reason but I hadn't did anything to anyone, I don't want to go back there, my family member will take me home to (name of home State). CR #1 was in Isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his hospital nurse, she said it did not look like his catheter had been taken care of. She said there were old wounds to the front and lateral shaft. She said there was a large laceration on his penis draining pus and the meatus was sliced open, not healed, and with a pink bed to it. Observation of CR #1 in his room at the Medical Center on [DATE] at 8:15 a.m. revealed he was alert and oriented to person and place. His skin was dry with mild swelling to his extremities. He answered questions appropriately and coherently. CR #1 said he was butchered and sore. CR #1 remained on isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his nurse, it was noted that he had a severe cut from the tip of the penis along the shaft and down to the bottom of his penis with an open wound around the shaft and about 80% granulation tissue and 20% slough. He had no Pressure ulcer. CR #1 was still being treated with intravenous and oral antibiotics. The hospital nurse said they were treating the wound with wet to dry dressing changes. During an interview on [DATE] at 4:40 p.m., the Director of Nursing said that CR #1 was admitted into the facility with an indwelling catheter on [DATE]. When asked why his admission MDS assessment did not show documentation of the catheter, she said that she did not know. When asked about CR #1's wound assessment, the DON said his pressure ulcer was a stage 2 on his sacrum. She said that she did the resident's admission skin assessment in the presence of two other staff and that the wound was a stage 2 and it healed within three days. During an interview on [DATE] at 5:24 p.m. with CNA 57 in regards to CR #1 she was asked did she ever provide care for him and she answered, I don't remember, never took care of him. During an interview on [DATE] at 5:45 p.m., the DON said CR #1 was admitted from hospital with the catheter and that it was placed on [DATE] at the hospital. She also said the resident had the catheter placed due to [MEDICAL CONDITION] and [MEDICAL CONDITION] bladder. During an interview on [DATE] at 10:13 a.m. with LVN CE, she said in regards to CR #1 he used to sing and everything while doing his care. His right arm was swollen when he came. She said she would help the Treatment Nurse turn him. She said he had a Foley catheter. She said she knew she had taken care of him through the week but could not remember the day. She said his hand was hurting and she gave him a [MEDICATION NAME] and breathing treatment. She said he was sitting up in a chair. She said she could remember that when you got him out of bed, all he wanted to do was go back to bed and he liked to talk. During an interview on [DATE] at 11:00 a.m., the Treatment Nurse (RN AB) said CR #1 had intermittent confusion, his bottom and scrotum were intact. He had a Foley catheter. During an interview on [DATE] at 11:43 a.m. with CNA 31, she said she remembered CR #1. She said she was out for about 6 weeks and returned on the 7th of August. She said CR #1 was a real nice gentleman. She said he started going to the dining room, was taking therapy, and she would give him his showers on Monday, Wednesday and Friday. She said there were no concerns for him. She said he had a little red area on his buttocks and she documented it on the shower sheet and in a couple of days the red area was gone. She said he was incontinent of both bowel and bladder, no Foley or ostomy, but could not really remember. During an interview on [DATE] at 11:51 a.m. with CNA 44, she said that CR #1 was nice, sweet, and that she helped him with everything, he asked, showers, and assist to chair. She said he was incontinent of bowel and bladder and had a urinary catheter. She said there were no problems or skin issues. During an interview on [DATE] at 12:00 p.m., the ADON when asked what she knew about CR #1, she said he was admitted during the middle of July, had an indwelling catheter, and [MEDICAL CONDITIONS] with [MEDICAL CONDITION]. She said the resident was cognitively confused intermittently and complained of pain to the Right shoulder. When asked whether she had any discussion with CR #1's Physician or NP's recently she said not that she could .remember or think of. When asked whether she had discussed with the Nurse Practitioner (NP) with the therapy department she said that Nurse Practitioner (NP) on one occasion said to her in a joking manner something about the resident's catheter and that he, CR #1, said he was going to call an Attorney. She said she did not know what the complaint was about and that it took place about 3 weeks prior. She also said she asked the nurses if CR #1 had complained to them about his catheter and they said no. When asked whether he was being given showers she said she had seen staff take him for showers. A request was made to review the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) shower sheets from admission to his discharge. When asked if the NP discussed with her the Resident's complaint of pain of his privates she said she never discussed anything about that with her. She also said the resident had never complained to her or the staff about pain to his private area or with the catheter. When asked if she assessed the resident's catheter when the NP notified her of resident's complaints about his catheter, she said that she looked at the drainage bag and tubing and it was clean and she did not check the catheter or his penis because he was sitting in his chair. She said if the NP had told her about pain in the resident's private area she would have assessed the area and would have notified the DON and resident's Physician. During a telephone interview on [DATE] at 12:06 p.m., CNA 16 said that she worked at the facility PRN (as needed) and that she had taken care of CR #1. She said that he had a Foley catheter and sores in his private area, looks like he has a cut down there. When asked if she notified her nurse, she said she did not notify the nurse because the sores and cut looked like they had been there for a long time. She said she would have thought the nurses should have known and that as a PRN staff she had not worked since the last few weeks. She said that while cleaning him she had to be careful because it hurt him. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 16 took care of him on [DATE], [DATE], [DATE], [DATE] and [DATE]. Resident was sent to the hospital on [DATE]. Additionally, record review of the Catheter Output Roster revealed that from [DATE] (admitted) to [DATE] (discharge date) staff were documenting that Catheter care was provided each day as follows: [DATE] - 1 time [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 4 times [DATE] - 2 times [DATE] - 1 time [DATE] - 5 times [DATE] - 2 times [DATE] - 3 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 1 time [DATE] - 5 times [DATE] - 3 times [DATE] - 2 times No documentation from any staff reporting of CR #1 having wound to his penis and sediments in his urine. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 57 signed indicating she provided care for CR #1 on the following days: [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. During an interview on [DATE] at 2:47 p.m. with CNA 57, she was asked about caring for CR #1 again and was shown his picture from his medical record and where she had documented care, including Foley catheter care. She said she recalled care provided saying she never took care of his catheter but could remember feeding him. When asked why did she sign that all care was provided on her on behalf, she replied, that she went around asking other CNA's about their residents things like output and care and entered the information in the kiosk for them in order to keep it from going into red. She said she would go ask the CNA's how much a resident ate and would go report to the nurse if there was a change in condition. She said no one ever told her about a problem with CR #1's catheter or penis but if they did, they were supposed to report it to the nurse. During an interview on [DATE] at 12:50 p.m., the DON she said CR #1 was admitted to the facility with an indwelling catheter but could not remember whether it was changed or not and that best practice should be to document date /time when catheter/bag/ tubing was changed. She also said she did not receive any report and did not hear that he was complaining of pain in his private area. The DON said the implications of not assessing a resident's catheter could be possible retention of urine, and swelling in his pubic area and penis. When asked if staff doing catheter or incontinent care would have seen it if the resident had swelling, sores, and cuts, she said yes, they should have noticed that but if they did not report it nobody would know. Record review of CR #1's shower sheet for [DATE] and [DATE] revealed no documentation of any abnormal finding or wound to the resident's penis. There were no shower sheets for the other days from [DATE] to [DATE]. During a telephone interview on [DATE] at 3:50 p.m. with Physician A, he said he did not receive any calls from the facility regarding sores/cuts or wound on CR #1's penis and he was not notified about his having sediment in his urine. During an interview on [DATE] at 11:55 a.m., the NP for the therapy department said CR #1 had complained to her a couple of times that he was having pain in his privates anytime he saw her and he explained to her that the pain could be from his catheter. The NP said she checked with the nurses and they said he did not complain to them about pain in his catheter or his private area. She also said she had a discussion with the ADON regarding the resident's complaint of pain to his privates and asked for her to look into it and follow up with his Physician. When asked what she would usually do if she had any issues or complaints from any resident, she said she would notify nursing and if the resident's Physician was available, she would mention it to them. She said it was not in her role to assess resident's privates/penis but to notify nursing and she was not sure if he had any problem with his privates or that it was emergent and did not convey it to the ADON as if it was emergent. When asked when she started seeing CR #1, she said from [DATE] to [DATE]. During an interview on [DATE] at 11:25 a.m., the DON when asked whether a staff should document care another person performed, she said that catheter care was done by CNA's and nurses performed care of Suprapubic catheters. She said that whoever did the care should document it and that a CNA should not document care performed by another CNA. Resident #15 Record review of Resident #15's Admission record revealed he was [AGE] years old and was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #15's Admission MDS assessment dated [DATE] revealed he was assessed as having a BIMS score of 11 indicating moderately impaired cognition. He was totally dependent on staff for transfers, dressing, eating, toilet use, personal hygiene, and bathing. He needed the extensive assistance of staff with bed mobility. Record review of Resident #15's plan of care dated [DATE] revealed a plan of care for being at risk for complications related to Cardiac Pace Maker in place, at risk for impaired cardiovascular functions, staff assistance for all ADL's, full code, difficulty recalling recent events and use of indwelling suprapubic catheter due to [MEDICAL CONDITION] bladder and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 6) at risk for developing Urinary Tract Infections. Record review of Resident #15's Nurses notes for [DATE] revealed documentation of vital signs/status of resident (per nursing - time reflected was when nurses documented the vitals and not necessarily when the vitals were taken) as follows: --[DATE] at 6:25 a.m. - RN AA documented Resident #15's Temperature 100.5 degrees Fahrenheit, axillary. MD notified, STAT labs and Chest X-ray ordered. --[DATE] at 11:03 a.m. - LVN/Unit Manager (UM) documented that Chest X-ray result revealed left lower lobe increased opacity with consideration for pneumonia, atelectasis and pleural effusion. Notified attending Physician and awaiting response. --[DATE] at 11:21 a.m. - RN AD documented for vital signs taken at 9:00 a:m (per interview with RN AD on [DATE] at 12:20 p.m.): O2 Saturation (SAT) 82% on Room Air (RA), Respiration (Resp) 20, Pulse(P) 123 bpm; resident was put on Oxygen (O2) at 2 liters and Blood Pressure (BP) ,[DATE] mmHg; Physician/Responsible Party (RP) notified. --[DATE] at 11:30 a.m. - RN AD documented she noted the Suprapubic catheter was draining scant urine, MD notified with order to replace catheter, consent obtained from responsible party. --[DATE] at 1:17 p.m. - LVN M documented Resident was difficult to arouse upon verbal and tactile stimuli upon arrival of a visitor. Resp. (respirations) 14 bpm (breathes per minute) , BP (blood pressure) ,[DATE], P (pulse) 62 and no temp. (temperature) and no 02 SAT (oxygen saturation). --[DATE] at 1:32 p.m. - LVN M documented temp. 99 temporal, MD notified and ordered to send Resident #1 out to VA hospital. Contracted Ambulance Response notified at 1:00 p.m. --[DATE] at 2:15 p.m. - LVN M documented - Non rebreather mask applied to resident with O2 (Oxygen) at 15 liters, resident remains stable at this time, 911 arrived at 2:10 p.m., report given, resident still breathing. --[DATE] at 3:00 p.m. - LVN M documented - Addendum: Contracted transport ambulance refused to transport resident due to their assessment of resident which resulted in 911 being called. --[DATE] at 3:31 p.m. - LVN/UM documented a late entry for 2:20 p.m. - 911 in room performing Cardiopulmonary Resuscitation (CPR) on resident starting approximately 2:15 p.m. and [MEDICATION NAME] 15 minutes. Resident left via stretcher escorted by 911 staff. Family members at bedside, attending physician updated. During an interview with Physician #2 on [DATE] at 3:15 p.m. he said that initially he was called about Resident #15 and was told that the resident was not doing well and he ordered some blood work, urine test and chest x-ray. He said he received another call notifying him of the chest x-ray results and that they had not received the results of other blood work. The Physician initially said he believed the staff did what they were supposed to do. He said he talked to the staff at the hospital and they said the resident basically coded. He also said when he spoke with the Medical Examiner he told him he did not need an autopsy and that the body had been released to the funeral home. When asked to explain further, he said that Medical examiners look for wrong doing for an autopsy to be done. When asked if he left any parameters or guidelines as to when to be called he said no and that it was easier to just call him when they have any issues. When asked of the Physician if the facility notified him when Resident #15's O2 SAT dropped to 82% in the morning; when they could not get O2 SAT on him later that morning; when his BP dropped to ,[DATE] and when he became difficult to arouse upon verbal and tactile stimuli, he said he was not notified of those findings and did not know about the situation. When asked what he would have expected the facility to do in those situations, he said he would expect staff to call him immediately. During a confidential interview the person said that they were concerned about the amount of time it took for Resident #15 to receive medical attention including transporting the resident to the hospital. This person raised concerns about the facility in that they failed to call 911 earlier and felt that Resident #15 would still be alive if medical attention needed and transport by 911 were contacted. They said there was confusion during his time of need. He stayed at the facility for two hours instead of being transferred properly. During an interview on [DATE] at 1:45 p.m., LVN M said she was the desk nurse on the date of the incident, [DATE] and that as the desk nurse she was responsible for charting skin assessments, weekly notes, antibiotic charting, and getting paper work ready for resident appointments amongst other tasks. She said she knew what was happening when a visitor came to the desk and said she was Resident #15's visitor and his condition was not good and wanted to know what was happening. She also said RN AD was the floor nurse that had the resident. She further said she went to the room with RN AD to assess the resident and did vital signs on him as follows: BP ,[DATE], P 62, and Resp. ,[DATE] and could not get O2 reading. She said the resident did not respond to his name. She said RN AD left the room and came back and told her the resident was going to be sent out. At about 1:30 p.m. LVN M wrote the transfer order, and prepared transfer papers. She said she did not know what time the transportation was called but noted transport arrived about 1:50 p.m. She said that when transport arrived, they came to the desk and told her they could not transport Resident #15 because they did not have the proper equipment. She called the DON and she said to call 911. When 911 staff came most of the staff went to the room. She said she documented what she was asked to write by LVN/UM. When asked what she should do when a resident had a change in condition, she said assess the resident, obtain vital signs, call the MD, notify DON/RP, and follow MD orders. She said if a resident's condition became worse she would call 911 and notify the MD. LVN M was able to enumerate what to do when she got a new admission including assessment of skin and indwelling catheter - when it was inserted and how urine looks. She said she should get physician's orders [REDACTED]. During an interview on [DATE] at 3:30 p.m., LVN/UM said she was made aware by RN AD that Resident #15 had a temperature of 100.5 degrees Fahrenheit and she gave him Tylenol. She said they document vital signs on their nurse's notes and some on the Medication Administration Record [REDACTED]. She said she was on another hall when she learned about the resident's condition and on getting to the room [ROOM NUMBER] was already there doing CPR. She said the DON with other nurses were in the room. She said she knew the MD was notified of X-ray results but not when his O2 SAT dropped/vital signs. When asked what staff should do when a resident had a change in condition, said they should assess resident including getting vital signs and O2 SAT, call MD and RP and carry out MD orders. She also said others should be documented in the nurse's notes and on their SBAR. She said nurses should not administer medications/treatments without a physician's orders [REDACTED]. During an interview on [DATE] at 5:12 p.m., the DON when asked whether she knew Resident #15 had a change in condition and what happened, she said she knew he had a change in condition and was going to the hospital. She then said she received a call from the nurse that the transport company refused to transport Resident #15 because they could not get an O2 SAT reading on him. She said 911 was already called. She said when she got to the room the resident was still breathing, 911 staff came, checked and obtained his pulse, and then started bagging him and putting in an IV catheter. When the 911 staff came into the room, they intubated him and started CPR. She further said they worked on him for a while before taking him to the ER. When asked whether they should have called 911 instead of the ambulance transport service they use she said the staff had called the ambulance transport service because the resident was clinically stable. She also said when his O2 SAT dropped to 82% Oxygen was applied and he was always having high heart rate even on admission. She said she did not know staff could not get his O2 SAT at 1:17 p.m. as per the nurse's notes and did not know if vital signs were done between the hours of 11:21 a.m. and 1:17 p.m. She said there were many people in the room and thought vital signs were done during that time frame. Requested documentation of the vital signs/monitoring of the resident during the time frame, none was provided provided prior to exit on [DATE]. When the DON was asked if she conducted an investigation regarding the incident, she said yes and she felt anything that needed to be done was done. Surveyor requested for the investigation report. The DON left the room and returned about 10 minutes later and said she did not write the report unless the surveyor wanted her to go and write one then. During an interview on [DATE] at 10:00 a.m., the DON when asked who was responsible for making decisions as to whether to call 911 or call their contracted Ambulance service she said the Charge Nurse was the person to make the decision. If the condition worsened, the nurses could make the decisions and then notify her. She said she could update or change the decision if she was available. When asked if Resident #15's Physician had parameters or guidelines as to when staff should call him, she said no that only Resident #1's Physician had parameters. During an interview with the contracted ambulance transport dispatcher on [DATE] at 11:13 a.m., he said he received the call from Afton Oaks around 1:00 p.m. and when he asked the nurse the resident's status, she said Altered Mental Status and that it took staff about ½ hour to get to the facility. He said the staff that went to the facility said upon arrival, the nurse said the resident just got sick. They said that when they got to the room, the resident was breathing but they could not get his Oxygen Saturation on him with their machine. So, they advised them to call 911 and left. Requested for a copy of their run sheet. He said he would fax it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) During a telephone interview on [DATE] at 12:20 p.m., RN AD acknowledged she had Resident #15 on the day shift on [DATE]. She said that when she made rounds that resident was talking and carried on conversation. She said she took the resident's vital signs between 9:00 a.m. and 9:30 a.m. and his O2 SAT was low. She said she notified her supervisor - LVN/UM, put him on O2 at 2 liters and notified Physician #2. She said resident had a temperature and was given Tylenol and Physician #2 was also notified and he ordered Stat laboratory tests, urine tests and x-ray which were performed. When asked why the resident was not monitored including checking his vital signs between when she (TRUNCATED)
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide services that meet professional standards of quality for 2 of 18 residents (CR#1 and #15) reviewed for professional standards in that: --The facility failed to ensure CR #1 had physician orders [REDACTED]. --The facility failed to arrange timely emergency transportation on [DATE] at approximately 9:,[DATE]:30 a.m. for Resident #15 when his oxygen saturation dropped to 82%. 911 was not called until 1:00 p.m., approximately 4 hours later. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility needed additional time to monitor and evaluate the effectiveness of their plan. This failure affected 1 hospitalized and 1 current resident and placed 11 additional residents in the facility with an indwelling catheter at risk of injury, harm, delayed medical treatment intervention, and possible hospitalization or death. Intake # 7 and # 2 Findings include: Record review of the Texas Administrative Code, Title 22, Part 11, Chapter 217 of the Texas Board of Nursing revealed in part: .The unprofessional conduct rules are intended to protect clients and the public from incompetent, unethical, or illegal conduct of licensees. The purpose of these rules is to identify unprofessional or dishonorable behaviors of a nurse which the board believes are likely to deceive, defraud, or injure clients or the public. Actual injury to a client need not be established. These behaviors include but are not limited to: . (6) Misconduct--actions or conduct that include, but are not limited to: .(C) Causing or permitting physical, emotional or verbal abuse or injury or neglect to the client or the public, or failing to report same to the employer, appropriate legal authority and/or licensing board; . Closed Record #1 Record review of CR #1's admission record revealed he was [AGE] years old and was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. He was discharged to the hospital on [DATE]. Record review of CR #1's Admission Nurse's notes by LVN U dated [DATE] revealed CR #1 was incontinent of bowel and bladder and there was no documentation of the presence of an indwelling urinary catheter. No other nurses' notes showed he had an indwelling catheter or that the catheter was changed through the time he was discharged . Record review of CR # 1's Admission Clinical Health Status note dated [DATE] documented his elimination and skin condition as follows: --Bladder: Incontinent. There was no documentation of him having an indwelling urinary catheter. The notes documented he was assessed as, incontinent of bowel and bladder. Record review of CR #1's Admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 5 indicating he had severely impaired cognition. He required extensive assistance for dressing, toilet use, and personal hygiene. He required total care with bathing. CR #1 needed supervision for eating and [DIAGNOSES REDACTED]. The MDS did not note the presence of his indwelling urinary catheter. His skin assessment revealed no pressure ulcer but that the resident was at risk of developing pressure ulcers. Record review of CR #1's Discharge MDS assessment dated [DATE] revealed no BIMS score documented. He required extensive assistance for dressing, toilet use, personal hygiene, and total care with bathing. CR #1 needed limited assistance for eating. Assessment of bowel and bladder revealed he was always incontinent of bowel and frequently incontinent of bladder. No skin assessment documented. Record review of Resident # 1's Care Plan for Activities of daily living (ADL) , not dated and not signed, had conflicting interventions. The intervention for bladder function revealed staff to assist resident as needed and record each shift whether he had voided. The same care plan had another intervention that stated resident had urinary catheter and directed staff to provide catheter care and record output. Record review of CR #1's unsigned physician's orders [REDACTED]. There were no admission orders [REDACTED] Record review of CR #1's Medication Admission Record dated July and [DATE] revealed no documented schedule or care for his indwelling urinary catheter. Record review of CR #1's Progress Notes for the month of [DATE] documented by the Nurse Practitioner (NP) for the Therapy department revealed as follows: --[DATE]: He was also complaining about pain in his 'privates.' --[DATE]: He wanted to know who was taking care of his privates now and he was told that the PCP (Primary Care Physician) at Afton was in charge. I discussed his problem with the ADON and she will talk to the patient about his concerns. He stated that other than his pain in his privates he felt ok. --[DATE]: The patient was still complaining about not understanding why he has a problem with his 'privates'. Per nursing, he only seems to complain about the catheter when I am present. Record review of CR#1's clinical record revealed no documentation of follow up care or physician notification. During an interview on [DATE] at 3:23 p.m. with the House Supervisor at the local hospital, she said her concern was that upon admission, CR #1's Foley catheter was dirty, his penis was filleted, it was open and he (Resident # 1) was septic. Record review of CR #1's medical records from the the local hospital obtained on [DATE] revealed he was admitted to the emergency room of the hospital on [DATE] at 13:22 p.m. and upon nursing assessment, it was noted, .Foley in place extremely dirty with sediments all along tube walls, patient's penis is split open from the bottom along the shaft. Urine dark brown It was also documented that CR #1 had [MEDICAL CONDITION] +2 to Right upper arm, right elbow, right forearm, left midcalf, left ankle, left upper arm, left elbow, left forearm, right midcalf and right ankle. Record review of the Physician's Progress Notes from the local hospital dated [DATE] at 9:55 p.m. revealed assessment and plan as follows: --Sepsis secondary to healthcare-associated pneumonia and urinary tract infection secondary to [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) and [MEDICATION NAME]. Urologist consult report from the local hospital dated [DATE] revealed as follows: --the patient noted on a thorough exam by ICU to have an indwelling Foley catheter for unknown reasons and found to have significant traumatic [DIAGNOSES REDACTED] from the Foley catheter. --the patient was previously admitted in the hospital in July and was discharged after a two-week stay to nursing home with a Foley catheter --Foley catheter presumed to be in place for likely [MEDICAL CONDITION] and there was no records found to document whether Foley catheter has been changed or not at the nursing home. The Urologist assessment revealed that the indwelling catheter was in place with approximately 5 cm of traumatic [DIAGNOSES REDACTED] and ventral erosion likely from Foley catheter and stated that the patient needs the Foley catheter to be exchanged and that he could benefit from a suprapubic tube in the future if he desires. Additionally, Nurses Shift Goals- Integumentary from the local hospital documented on [DATE] at 7:00 a.m. noted penile shaft open wound approx. ,[DATE] inch long, monitor s/sx (signs/symptoms) of infection. Observation and interview of CR #1 in his room at the local hospital on [DATE] at 10:59 a.m. with the hospital nurse and social worker present revealed he was alert and oriented to person and place. His right hand was swollen. He answered questions appropriately and coherently. CR #1 said, I will be [AGE] years old and never had something like this happen like

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) this, someone cut it-someone cut it completely open down the shaft . He added the service he received at Afton Oaks was not good. He said, It looks like someone didn't like me, for some reason but I hadn't did anything to anyone, I don't want to go back there, my family member will take me home to (name of home State). CR #1 was in Isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his hospital nurse, she said it did not look like his catheter had been taken care of. She said there were old wounds to the front and lateral shaft. She said there was a large laceration on his penis draining pus and the meatus was sliced open, not healed, and with a pink bed to it. Observation of CR #1 in his room at the Medical Center on [DATE] at 8:15 a.m. revealed he was alert and oriented to person and place. His skin was dry with mild swelling to his extremities. He answered questions appropriately and coherently. CR #1 said he was butchered and sore. CR #1 remained on isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his nurse, it was noted that he had a severe cut from the tip of the penis along the shaft and down to the bottom of his penis with an open wound around the shaft and about 80% granulation tissue and 20% slough. He had no Pressure ulcer. CR #1 was still being treated with intravenous and oral antibiotics. The hospital nurse said they were treating the wound with wet to dry dressing changes. During an interview on [DATE] at 4:40 p.m., the Director of Nursing said that CR #1 was admitted into the facility with an indwelling catheter on [DATE]. When asked why his admission MDS assessment did not show documentation of the catheter, she said that she did not know. When asked about CR #1's wound assessment, the DON said his pressure ulcer was a stage 2 on his sacrum. She said that she did the resident's admission skin assessment in the presence of two other staff and that the wound was a stage 2 and it healed within three days. During an interview on [DATE] at 5:24 p.m. with CNA 57 in regards to CR #1 she was asked did she ever provide care for him and she answered, I don't remember, never took care of him. During an interview on [DATE] at 5:45 p.m., the DON said CR #1 was admitted from hospital with the catheter and that it was placed on [DATE] at the hospital. She also said the resident had the catheter placed due to [MEDICAL CONDITION] and [MEDICAL CONDITION] bladder. During an interview on [DATE] at 10:13 a.m. with LVN CE, she said in regards to CR #1 he used to sing and everything while doing his care. His right arm was swollen when he came. She said she would help the Treatment Nurse turn him. She said he had a Foley catheter. She said she knew she had taken care of him through the week but could not remember the day. She said his hand was hurting and she gave him a [MEDICATION NAME] and breathing treatment. She said he was sitting up in a chair. She said she could remember that when you got him out of bed, all he wanted to do was go back to bed and he liked to talk. During an interview on [DATE] at 11:00 a.m., the Treatment Nurse (RN AB) said CR #1 had intermittent confusion, his bottom and scrotum were intact. He had a Foley catheter. During an interview on [DATE] at 11:43 a.m. with CNA 31, she said she remembered CR #1. She said she was out for about 6 weeks and returned on the 7th of August. She said CR #1 was a real nice gentleman. She said he started going to the dining room, was taking therapy, and she would give him his showers on Monday, Wednesday and Friday. She said there were no concerns for him. She said he had a little red area on his buttocks and she documented it on the shower sheet and in a couple of days the red area was gone. She said he was incontinent of both bowel and bladder, no Foley or ostomy, but could not really remember. During an interview on [DATE] at 11:51 a.m. with CNA 44, she said that CR #1 was nice, sweet, and that she helped him with everything, he asked, showers, and assist to chair. She said he was incontinent of bowel and bladder and had a urinary catheter. She said there were no problems or skin issues. During an interview on [DATE] at 12:00 p.m., the ADON when asked what she knew about CR #1, she said he was admitted during the middle of July, had an indwelling catheter, and [MEDICAL CONDITIONS] with [MEDICAL CONDITION]. She said the resident was cognitively confused intermittently and complained of pain to the Right shoulder. When asked whether she had any discussion with CR #1's Physician or NP's recently she said not that she could .remember or think of. When asked whether she had discussed with the Nurse Practitioner (NP) with the therapy department she said that Nurse Practitioner (NP) on one occasion said to her in a joking manner something about the resident's catheter and that he, CR #1, said he was going to call an Attorney. She said she did not know what the complaint was about and that it took place about 3 weeks prior. She also said she asked the nurses if CR #1 had complained to them about his catheter and they said no. When asked whether he was being given showers she said she had seen staff take him for showers. A request was made to review the resident's shower sheets from admission to his discharge. When asked if the NP discussed with her the Resident's complaint of pain of his privates she said she never discussed anything about that with her. She also said the resident had never complained to her or the staff about pain to his private area or with the catheter. When asked if she assessed the resident's catheter when the NP notified her of resident's complaints about his catheter, she said that she looked at the drainage bag and tubing and it was clean and she did not check the catheter or his penis because he was sitting in his chair. She said if the NP had told her about pain in the resident's private area she would have assessed the area and would have notified the DON and resident's Physician. During a telephone interview on [DATE] at 12:06 p.m., CNA 16 said that she worked at the facility PRN (as needed) and that she had taken care of CR #1. She said that he had a Foley catheter and sores in his private area, looks like he has a cut down there. When asked if she notified her nurse, she said she did not notify the nurse because the sores and cut looked like they had been there for a long time. She said she would have thought the nurses should have known and that as a PRN staff she had not worked since the last few weeks. She said that while cleaning him she had to be careful because it hurt him. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 16 took care of him on [DATE], [DATE], [DATE], [DATE] and [DATE]. Resident was sent to the hospital on [DATE]. Additionally, record review of the Catheter Output Roster revealed that from [DATE] (admitted) to [DATE] (discharge date) staff were documenting that Catheter care was provided each day as follows: [DATE] - 1 time [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 4 times [DATE] - 2 times [DATE] - 1 time [DATE] - 5 times [DATE] - 2 times [DATE] - 3 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0281 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 9) [DATE] - 3 times [DATE] - 3 times [DATE] - 1 time [DATE] - 5 times [DATE] - 3 times [DATE] - 2 times No documentation from any staff reporting of CR #1 having wound to his penis and sediments in his urine. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 57 signed indicating she provided care for CR #1 on the following days: [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. During an interview on [DATE] at 2:47 p.m. with CNA 57, she was asked about caring for CR #1 again and was shown his picture from his medical record and where she had documented care, including Foley catheter care. She said she recalled care provided saying she never took care of his catheter but could remember feeding him. When asked why did she sign that all care was provided on her on behalf, she replied, that she went around asking other CNA's about their residents things like output and care and entered the information in the kiosk for them in order to keep it from going into red. She said she would go ask the CNA's how much a resident ate and would go report to the nurse if there was a change in condition. She said no one ever told her about a problem with CR #1's catheter or penis but if they did, they were supposed to report it to the nurse. During an interview on [DATE] at 12:50 p.m., the DON she said CR #1 was admitted to the facility with an indwelling catheter but could not remember whether it was changed or not and that best practice should be to document date /time when catheter/bag/ tubing was changed. She also said she did not receive any report and did not hear that he was complaining of pain in his private area. The DON said the implications of not assessing a resident's catheter could be possible retention of urine, and swelling in his pubic area and penis. When asked if staff doing catheter or incontinent care would have seen it if the resident had swelling, sores, and cuts, she said yes, they should have noticed that but if they did not report it nobody would know. Record review of CR #1's shower sheet for [DATE] and [DATE] revealed no documentation of any abnormal finding or wound to the resident's penis. There were no shower sheets for the other days from [DATE] to [DATE]. During a telephone interview on [DATE] at 3:50 p.m. with Physician A, he said he did not receive any calls from the facility regarding sores/cuts or wound on CR #1's penis and he was not notified about his having sediment in his urine. During an interview on [DATE] at 11:55 a.m., the NP for the therapy department said CR #1 had complained to her a couple of times that he was having pain in his privates anytime he saw her and he explained to her that the pain could be from his catheter. The NP said she checked with the nurses and they said he did not complain to them about pain in his catheter or his private area. She also said she had a discussion with the ADON regarding the resident's complaint of pain to his privates and asked for her to look into it and follow up with his Physician. When asked what she would usually do if she had any issues or complaints from any resident, she said she would notify nursing and if the resident's Physician was available, she would mention it to them. She said it was not in her role to assess resident's privates/penis but to notify nursing and she was not sure if he had any problem with his privates or that it was emergent and did not convey it to the ADON as if it was emergent. When asked when she started seeing CR #1, she said from [DATE] to [DATE]. During an interview on [DATE] at 11:25 a.m., the DON when asked whether a staff should document care another person performed, she said that catheter care was done by CNA's and nurses performed care of Suprapubic catheters. She said that whoever did the care should document it and that a CNA should not document care performed by another CNA. Resident #15 Record review of Resident #15's Admission record revealed he was [AGE] years old and was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #15's Admission MDS assessment dated [DATE] revealed he was assessed as having a BIMS score of 11 indicating moderately impaired cognition. He was totally dependent on staff for transfers, dressing, eating, toilet use, personal hygiene, and bathing. He needed the extensive assistance of staff with bed mobility. Record review of Resident #15's plan of care dated [DATE] revealed a plan of care for being at risk for complications related to Cardiac Pace Maker in place, at risk for impaired cardiovascular functions, staff assistance for all ADL's, full code, difficulty recalling recent events and use of indwelling suprapubic catheter due to [MEDICAL CONDITION] bladder and at risk for developing Urinary Tract Infections. Record review of Resident #15's Nurses notes for [DATE] revealed documentation of vital signs/status of resident (per nursing - time reflected was when nurses documented the vitals and not necessarily when the vitals were taken) as follows: --[DATE] at 6:25 a.m. - RN AA documented Resident #15's Temperature 100.5 degrees Fahrenheit, axillary. MD notified, STAT labs and Chest X-ray ordered. --[DATE] at 11:03 a.m. - LVN/Unit Manager (UM) documented that Chest X-ray result revealed left lower lobe increased opacity with consideration for pneumonia, atelectasis and pleural effusion. Notified attending Physician and awaiting response. --[DATE] at 11:21 a.m. - RN AD documented for vital signs taken at 9:00 a:m (per interview with RN AD on [DATE] at 12:20 p.m.): O2 Saturation (SAT) 82% on Room Air (RA), Respiration (Resp) 20, Pulse(P) 123 bpm; resident was put on Oxygen (O2) at 2 liters and Blood Pressure (BP) ,[DATE] mmHg; Physician/Responsible Party (RP) notified. --[DATE] at 11:30 a.m. - RN AD documented she noted the Suprapubic catheter was draining scant urine, MD notified with order to replace catheter, consent obtained from responsible party. --[DATE] at 1:17 p.m. - LVN M documented Resident was difficult to arouse upon verbal and tactile stimuli upon arrival of a visitor. Resp. (respirations) 14 bpm (breathes per minute) , BP (blood pressure) ,[DATE], P (pulse) 62 and no temp. (temperature) and no 02 SAT (oxygen saturation). --[DATE] at 1:32 p.m. - LVN M documented temp. 99 temporal, MD notified and ordered to send Resident #1 out to VA hospital. Contracted Ambulance Response notified at 1:00 p.m. --[DATE] at 2:15 p.m. - LVN M documented - Non rebreather mask applied to resident with O2 (Oxygen) at 15 liters, resident remains stable at this time, 911 arrived at 2:10 p.m., report given, resident still breathing. --[DATE] at 3:00 p.m. - LVN M documented - Addendum: Contracted transport ambulance refused to transport resident due to their assessment of resident which resulted in 911 being called. --[DATE] at 3:31 p.m. - LVN/UM documented a late entry for 2:20 p.m. - 911 in room performing Cardiopulmonary Resuscitation (CPR) on resident starting approximately 2:15 p.m. and [MEDICATION NAME] 15 minutes. Resident left via stretcher escorted by 911 staff. Family members at bedside, attending physician updated. During an interview with Physician #2 on [DATE] at 3:15 p.m. he said that initially he was called about Resident #15 and was told that the resident was not doing well and he ordered some blood work, urine test and chest x-ray. He said he received another call notifying him of the chest x-ray results and that they had not received the results of other blood work. The Physician initially said he believed the staff did what they were supposed to do. He said he talked to the staff at the hospital and they said the resident basically coded. He also said when he spoke with the Medical Examiner he told him he did not need an autopsy and that the body had been released to the funeral home. When asked to explain further, he said that Medical examiners look for wrong doing for an autopsy to be done. When asked if he left any parameters or guidelines as to when to be called he said no and that it was easier to just call him when they have any issues. When asked of the Physician if the facility notified him when Resident #15's O2 SAT dropped to 82% in the morning; when they could not get O2 SAT on him later that morning; when his BP dropped to ,[DATE] and when he became difficult to arouse upon verbal and tactile stimuli, he said he was not notified of those findings and did not know about the situation. When asked what he would have expected the facility to do in those situations, he said he would expect staff to call him immediately. During a confidential interview the person said that they were concerned about the amount of time it took for Resident #15 to receive medical attention including transporting the resident to the hospital. This person raised concerns about the facility in that they failed to call 911 earlier and felt that Resident #15 would still be alive if medical attention needed and transport by 911 were contacted. They said there was confusion during his time of need. He stayed at the facility for two hours instead of being transferred properly. During an interview on [DATE] at 1:45 p.m., LVN M said she was the desk nurse on the date of the incident, [DATE] and that as the desk nurse she was responsible for charting skin assessments, weekly notes, antibiotic charting, and getting paper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0281 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 10) work ready for resident appointments amongst other tasks. She said she knew what was happening when a visitor came to the desk and said she was Resident #15's visitor and his condition was not good and wanted to know what was happening. She also said RN AD was the floor nurse that had the resident. She further said she went to the room with RN AD to assess the resident and did vital signs on him as follows: BP ,[DATE], P 62, and Resp. ,[DATE] and could not get O2 reading. She said the resident did not respond to his name. She said RN AD left the room and came back and told her the resident was going to be sent out. At about 1:30 p.m. LVN M wrote the transfer order, and prepared transfer papers. She said she did not know what time the transportation was called but noted transport arrived about 1:50 p.m. She said that when transport arrived, they came to the desk and told her they could not transport Resident #15 because they did not have the proper equipment. She called the DON and she said to call 911. When 911 staff came most of the staff went to the room. She said she documented what she was asked to write by LVN/UM. When asked what she should do when a resident had a change in condition, she said assess the resident, obtain vital signs, call the MD, notify DON/RP, and follow MD orders. She said if a resident's condition became worse she would call 911 and notify the MD. LVN M was able to enumerate what to do when she got a new admission including assessment of skin and indwelling catheter - when it was inserted and how urine looks. She said she should get physician's orders [REDACTED]. During an interview on [DATE] at 3:30 p.m., LVN/UM said she was made aware by RN AD that Resident #15 had a temperature of 100.5 degrees Fahrenheit and she gave him Tylenol. She said they document vital signs on their nurse's notes and some on the Medication Administration Record [REDACTED]. She said she was on another hall when she learned about the resident's condition and on getting to the room [ROOM NUMBER] was already there doing CPR. She said the DON with other nurses were in the room. She said she knew the MD was notified of X-ray results but not when his O2 SAT dropped/vital signs. When asked what staff should do when a resident had a change in condition, said they should assess resident including getting vital signs and O2 SAT, call MD and RP and carry out MD orders. She also said others should be documented in the nurse's notes and on their SBAR. She said nurses should not administer medications/treatments without a physician's orders [REDACTED]. During an interview on [DATE] at 5:12 p.m., the DON when asked whether she knew Resident #15 had a change in condition and what happened, she said she knew he had a change in condition and was going to the hospital. She then said she received a call from the nurse that the transport company refused to transport Resident #15 because they could not get an O2 SAT reading on him. She said 911 was already called. She said when she got to the room the resident was still breathing, 911 staff came, checked and obtained his pulse, and then started bagging him and putting in an IV catheter. When the 911 staff came into the room, they intubated him and started CPR. She further said they worked on him for a while before taking him to the ER. When asked whether they should have called 911 instead of the ambulance transport service they use she said the staff had called the ambulance transport service because the resident was clinically stable. She also said when his O2 SAT dropped to 82% Oxygen was applied and he was always having high heart rate even on admission. She said she did not know staff could not get his O2 SAT at 1:17 p.m. as per the nurse's notes and did not know if vital signs were done between the hours of 11:21 a.m. and 1:17 p.m. She said there were many people in the room and thought vital signs were done during that time frame. Requested documentation of the vital signs/monitoring of the resident during the time frame, none was provided provided prior to exit on [DATE]. When the DON was asked if she conducted an investigation regarding the incident, she said yes and she felt anything that needed to be done was done. Surveyor requested for the investigation report. The DON left the room and returned about 10 minutes later and said she did not write the report unless the surveyor wanted her to go and write one then. During an interview on [DATE] at 10:00 a.m., the DON when asked who was responsible for making decisions as to whether to call 911 or call their contracted Ambulance service she said the Charge Nurse was the person to make the decision. If the condition worsened, the nurses could make the decisions and then notify her. She said she could update or change the decision if she was available. When asked if Resident #15's Physician had parameters or guidelines as to when staff should call him, she said no that only Resident #1's Physician had parameters. During an interview with the contracted ambulance transport dispatcher on [DATE] at 11:13 a.m., he said he received the call from Afton Oaks around 1:00 p.m. and when he asked the nurse the resident's status, she said Altered Mental Status and that it took staff about ½ hour to get to the facility. He said the staff that went to the facility said upon arrival, the nurse said the resident just got sick. They said that when they got to the room, the resident was breathing but they could not get his Oxygen Saturation on him
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 , interview, and record review the facility failed to ensure 2 of 18 residents (CR #1 and Resident #15) reviewed for quality of care received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care in that: --CR#1 was not provided with catheter assessment and care from admission on [DATE] through discharge on [DATE] to prevent and then treat injury to his penis. His penis was split from the meatus down the shaft to the scrotum. --Resident #15 had a significant change in condition on [DATE] that was not treated emergently resutling in delayed transportation, intervention, and treatment. He later died in the hospital on [DATE]. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility needed additional time to monitor and evaluate the effectiveness of their plan. These failures affected 1 hospitalized and 1 current resident and placed 11 additional residents in the facility with an indwelling catheter at risk of injury, harm, delayed medical treatment intervention, and possible hospitalization or death. Intake # 7 and # 2 Findings include: Closed Record #1 Record review of CR #1's admission record revealed he was [AGE] years old and was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. He was discharged to the hospital on [DATE]. Record review of CR #1's Admission Nurse's notes by LVN U dated [DATE] revealed CR #1 was incontinent of bowel and bladder and there was no documentation of the presence of an indwelling urinary catheter. No other nurses' notes showed he had an indwelling catheter or that the catheter was changed through the time he was discharged . Record review of CR # 1's Admission Clinical Health Status note dated [DATE] documented his elimination and skin condition as follows: --Bladder: Incontinent. There was no documentation of him having an indwelling urinary catheter. The notes documented he was assessed as, incontinent of bowel and bladder. Record review of CR #1's Admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 5 indicating he had severely impaired cognition. He required extensive assistance for dressing, toilet use, and personal hygiene. He required total care with bathing. CR #1 needed supervision for eating and [DIAGNOSES REDACTED]. The MDS did not note the presence of his indwelling urinary catheter. His skin assessment revealed no pressure ulcer but that the resident was at risk of developing pressure ulcers. Record review of CR #1's Discharge MDS assessment dated [DATE] revealed no BIMS score documented. He required extensive assistance for dressing, toilet use, personal hygiene, and total care with bathing. CR #1 needed limited assistance for eating. Assessment of bowel and bladder revealed he was always incontinent of bowel and frequently incontinent of bladder. No skin assessment documented. Record review of Resident # 1's Care Plan for Activities of daily living (ADL) , not dated and not signed, had conflicting interventions. The intervention for bladder function revealed staff to assist resident as needed and record each shift whether he had voided. The same care plan had another intervention that stated resident had urinary catheter and directed staff to provide catheter care and record output. Record review of CR #1's unsigned physician's orders [REDACTED]. There were no admission orders [REDACTED] Record review of CR #1's Medication Admission Record dated July and [DATE] revealed no documented schedule or care for his indwelling urinary catheter. Record review of CR #1's Progress Notes for the month of [DATE] documented by the Nurse Practitioner (NP) for the Therapy department revealed as follows: --[DATE]: He was also complaining about pain in his 'privates.'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 11) --[DATE]: He wanted to know who was taking care of his privates now and he was told that the PCP (Primary Care Physician) at Afton was in charge. I discussed his problem with the ADON and she will talk to the patient about his concerns. He stated that other than his pain in his privates he felt ok. --[DATE]: The patient was still complaining about not understanding why he has a problem with his 'privates'. Per nursing, he only seems to complain about the catheter when I am present. Record review of CR#1's clinical record revealed no documentation of follow up care or physician notification. During an interview on [DATE] at 3:23 p.m. with the House Supervisor at the local hospital, she said her concern was that upon admission, CR #1's Foley catheter was dirty, his penis was filleted, it was open and he (Resident # 1) was septic. Record review of CR #1's medical records from the the local hospital obtained on [DATE] revealed he was admitted to the emergency room of the hospital on [DATE] at 13:22 p.m. and upon nursing assessment, it was noted, .Foley in place extremely dirty with sediments all along tube walls, patient's penis is split open from the bottom along the shaft. Urine dark brown It was also documented that CR #1 had [MEDICAL CONDITION] +2 to Right upper arm, right elbow, right forearm, left midcalf, left ankle, left upper arm, left elbow, left forearm, right midcalf and right ankle. Record review of the Physician's Progress Notes from the local hospital dated [DATE] at 9:55 p.m. revealed assessment and plan as follows: --Sepsis secondary to healthcare-associated pneumonia and urinary tract infection secondary to [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) and [MEDICATION NAME]. Urologist consult report from the local hospital dated [DATE] revealed as follows: --the patient noted on a thorough exam by ICU to have an indwelling Foley catheter for unknown reasons and found to have significant traumatic [DIAGNOSES REDACTED] from the Foley catheter. --the patient was previously admitted in the hospital in July and was discharged after a two-week stay to nursing home with a Foley catheter --Foley catheter presumed to be in place for likely [MEDICAL CONDITION] and there was no records found to document whether Foley catheter has been changed or not at the nursing home. The Urologist assessment revealed that the indwelling catheter was in place with approximately 5 cm of traumatic [DIAGNOSES REDACTED] and ventral erosion likely from Foley catheter and stated that the patient needs the Foley catheter to be exchanged and that he could benefit from a suprapubic tube in the future if he desires. Additionally, Nurses Shift Goals- Integumentary from the local hospital documented on [DATE] at 7:00 a.m. noted penile shaft open wound approx. ,[DATE] inch long, monitor s/sx (signs/symptoms) of infection. Observation and interview of CR #1 in his room at the local hospital on [DATE] at 10:59 a.m. with the hospital nurse and social worker present revealed he was alert and oriented to person and place. His right hand was swollen. He answered questions appropriately and coherently. CR #1 said, I will be [AGE] years old and never had something like this happen like this, someone cut it-someone cut it completely open down the shaft . He added the service he received at Afton Oaks was not good. He said, It looks like someone didn't like me, for some reason but I hadn't did anything to anyone, I don't want to go back there, my family member will take me home to (name of home State). CR #1 was in Isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his hospital nurse, she said it did not look like his catheter had been taken care of. She said there were old wounds to the front and lateral shaft. She said there was a large laceration on his penis draining pus and the meatus was sliced open, not healed, and with a pink bed to it. Observation of CR #1 in his room at the Medical Center on [DATE] at 8:15 a.m. revealed he was alert and oriented to person and place. His skin was dry with mild swelling to his extremities. He answered questions appropriately and coherently. CR #1 said he was butchered and sore. CR #1 remained on isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his nurse, it was noted that he had a severe cut from the tip of the penis along the shaft and down to the bottom of his penis with an open wound around the shaft and about 80% granulation tissue and 20% slough. He had no Pressure ulcer. CR #1 was still being treated with intravenous and oral antibiotics. The hospital nurse said they were treating the wound with wet to dry dressing changes. During an interview on [DATE] at 4:40 p.m., the Director of Nursing said that CR #1 was admitted into the facility with an indwelling catheter on [DATE]. When asked why his admission MDS assessment did not show documentation of the catheter, she said that she did not know. When asked about CR #1's wound assessment, the DON said his pressure ulcer was a stage 2 on his sacrum. She said that she did the resident's admission skin assessment in the presence of two other staff and that the wound was a stage 2 and it healed within three days. During an interview on [DATE] at 5:24 p.m. with CNA 57 in regards to CR #1 she was asked did she ever provide care for him and she answered, I don't remember, never took care of him. During an interview on [DATE] at 5:45 p.m., the DON said CR #1 was admitted from hospital with the catheter and that it was placed on [DATE] at the hospital. She also said the resident had the catheter placed due to [MEDICAL CONDITION] and [MEDICAL CONDITION] bladder. During an interview on [DATE] at 10:13 a.m. with LVN CE, she said in regards to CR #1 he used to sing and everything while doing his care. His right arm was swollen when he came. She said she would help the Treatment Nurse turn him. She said he had a Foley catheter. She said she knew she had taken care of him through the week but could not remember the day. She said his hand was hurting and she gave him a [MEDICATION NAME] and breathing treatment. She said he was sitting up in a chair. She said she could remember that when you got him out of bed, all he wanted to do was go back to bed and he liked to talk. During an interview on [DATE] at 11:00 a.m., the Treatment Nurse (RN AB) said CR #1 had intermittent confusion, his bottom and scrotum were intact. He had a Foley catheter. During an interview on [DATE] at 11:43 a.m. with CNA 31, she said she remembered CR #1. She said she was out for about 6 weeks and returned on the 7th of August. She said CR #1 was a real nice gentleman. She said he started going to the dining room, was taking therapy, and she would give him his showers on Monday, Wednesday and Friday. She said there were no concerns for him. She said he had a little red area on his buttocks and she documented it on the shower sheet and in a couple of days the red area was gone. She said he was incontinent of both bowel and bladder, no Foley or ostomy, but could not really remember. During an interview on [DATE] at 11:51 a.m. with CNA 44, she said that CR #1 was nice, sweet, and that she helped him with everything, he asked, showers, and assist to chair. She said he was incontinent of bowel and bladder and had a urinary catheter. She said there were no problems or skin issues. During an interview on [DATE] at 12:00 p.m., the ADON when asked what she knew about CR #1, she said he was admitted during the middle of July, had an indwelling catheter, and [MEDICAL CONDITIONS] with [MEDICAL CONDITION]. She said the resident was cognitively confused intermittently and complained of pain to the Right shoulder. When asked whether she had any discussion with CR #1's Physician or NP's recently she said not that she could .remember or think of. When asked whether she had discussed with the Nurse Practitioner (NP) with the therapy department she said that Nurse Practitioner (NP) on one occasion said to her in a joking manner something about the resident's catheter and that he, CR #1, said he was going to call an Attorney. She said she did not know what the complaint was about and that it took place about 3 weeks prior. She also said she asked the nurses if CR #1 had complained to them about his catheter and they said no. When asked whether he was being given showers she said she had seen staff take him for showers. A request was made to review the resident's shower sheets from admission to his discharge. When asked if the NP discussed with her the Resident's complaint of pain of his privates she said she never discussed anything about that with her. She also said the resident had never complained to her or the staff about pain to his private area or with the catheter. When asked if she assessed the resident's catheter when the NP notified her of resident's complaints about his catheter, she said that she looked at the drainage bag and tubing and it was clean and she did not check the catheter or his penis because he was sitting in his chair. She said if the NP had told her about pain in the resident's private area she would have assessed the area and would have notified the DON and resident's Physician. During a telephone interview on [DATE] at 12:06 p.m., CNA 16 said that she worked at the facility PRN (as needed) and that she had taken care of CR #1. She said that he had a Foley catheter and sores in his private area, looks like he has a cut down there. When asked if she notified her nurse, she said she did not notify the nurse because the sores and cut looked like they had been there for a long time. She said she would have thought the nurses should have known and that as a PRN staff she had not worked since the last few weeks. She said that while cleaning him she had to be careful because it hurt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) him. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 16 took care of him on [DATE], [DATE], [DATE], [DATE] and [DATE]. Resident was sent to the hospital on [DATE]. Additionally, record review of the Catheter Output Roster revealed that from [DATE] (admitted) to [DATE] (discharge date) staff were documenting that Catheter care was provided each day as follows: [DATE] - 1 time [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 4 times [DATE] - 2 times [DATE] - 1 time [DATE] - 5 times [DATE] - 2 times [DATE] - 3 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 1 time [DATE] - 5 times [DATE] - 3 times [DATE] - 2 times No documentation from any staff reporting of CR #1 having wound to his penis and sediments in his urine. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 57 signed indicating she provided care for CR #1 on the following days: [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. During an interview on [DATE] at 2:47 p.m. with CNA 57, she was asked about caring for CR #1 again and was shown his picture from his medical record and where she had documented care, including Foley catheter care. She said she recalled care provided saying she never took care of his catheter but could remember feeding him. When asked why did she sign that all care was provided on her on behalf, she replied, that she went around asking other CNA's about their residents things like output and care and entered the information in the kiosk for them in order to keep it from going into red. She said she would go ask the CNA's how much a resident ate and would go report to the nurse if there was a change in condition. She said no one ever told her about a problem with CR #1's catheter or penis but if they did, they were supposed to report it to the nurse. During an interview on [DATE] at 12:50 p.m., the DON she said CR #1 was admitted to the facility with an indwelling catheter but could not remember whether it was changed or not and that best practice should be to document date /time when catheter/bag/ tubing was changed. She also said she did not receive any report and did not hear that he was complaining of pain in his private area. The DON said the implications of not assessing a resident's catheter could be possible retention of urine, and swelling in his pubic area and penis. When asked if staff doing catheter or incontinent care would have seen it if the resident had swelling, sores, and cuts, she said yes, they should have noticed that but if they did not report it nobody would know. Record review of CR #1's shower sheet for [DATE] and [DATE] revealed no documentation of any abnormal finding or wound to the resident's penis. There were no shower sheets for the other days from [DATE] to [DATE]. During a telephone interview on [DATE] at 3:50 p.m. with Physician A, he said he did not receive any calls from the facility regarding sores/cuts or wound on CR #1's penis and he was not notified about his having sediment in his urine. During an interview on [DATE] at 11:55 a.m., the NP for the therapy department said CR #1 had complained to her a couple of times that he was having pain in his privates anytime he saw her and he explained to her that the pain could be from his catheter. The NP said she checked with the nurses and they said he did not complain to them about pain in his catheter or his private area. She also said she had a discussion with the ADON regarding the resident's complaint of pain to his privates and asked for her to look into it and follow up with his Physician. When asked what she would usually do if she had any issues or complaints from any resident, she said she would notify nursing and if the resident's Physician was available, she would mention it to them. She said it was not in her role to assess resident's privates/penis but to notify nursing and she was not sure if he had any problem with his privates or that it was emergent and did not convey it to the ADON as if it was emergent. When asked when she started seeing CR #1, she said from [DATE] to [DATE]. During an interview on [DATE] at 11:25 a.m., the DON when asked whether a staff should document care another person performed, she said that catheter care was done by CNA's and nurses performed care of Suprapubic catheters. She said that whoever did the care should document it and that a CNA should not document care performed by another CNA. Resident #15 Record review of Resident #15's Admission record revealed he was [AGE] years old and was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #15's Admission MDS assessment dated [DATE] revealed he was assessed as having a BIMS score of 11 indicating moderately impaired cognition. He was totally dependent on staff for transfers, dressing, eating, toilet use, personal hygiene, and bathing. He needed the extensive assistance of staff with bed mobility. Record review of Resident #15's plan of care dated [DATE] revealed a plan of care for being at risk for complications related to Cardiac Pace Maker in place, at risk for impaired cardiovascular functions, staff assistance for all ADL's, full code, difficulty recalling recent events and use of indwelling suprapubic catheter due to [MEDICAL CONDITION] bladder and at risk for developing Urinary Tract Infections. Record review of Resident #15's Nurses notes for [DATE] revealed documentation of vital signs/status of resident (per nursing - time reflected was when nurses documented the vitals and not necessarily when the vitals were taken) as follows: --[DATE] at 6:25 a.m. - RN AA documented Resident #15's Temperature 100.5 degrees Fahrenheit, axillary. MD notified, STAT labs and Chest X-ray ordered. --[DATE] at 11:03 a.m. - LVN/Unit Manager (UM) documented that Chest X-ray result revealed left lower lobe increased opacity with consideration for pneumonia, atelectasis and pleural effusion. Notified attending Physician and awaiting response. --[DATE] at 11:21 a.m. - RN AD documented for vital signs taken at 9:00 a:m (per interview with RN AD on [DATE] at 12:20 p.m.): O2 Saturation (SAT) 82% on Room Air (RA), Respiration (Resp) 20, Pulse(P) 123 bpm; resident was put on Oxygen (O2) at 2 liters and Blood Pressure (BP) ,[DATE] mmHg; Physician/Responsible Party (RP) notified. --[DATE] at 11:30 a.m. - RN AD documented she noted the Suprapubic catheter was draining scant urine, MD notified with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 13) order to replace catheter, consent obtained from responsible party. --[DATE] at 1:17 p.m. - LVN M documented Resident was difficult to arouse upon verbal and tactile stimuli upon arrival of a visitor. Resp. (respirations) 14 bpm (breathes per minute) , BP (blood pressure) ,[DATE], P (pulse) 62 and no temp. (temperature) and no 02 SAT (oxygen saturation). --[DATE] at 1:32 p.m. - LVN M documented temp. 99 temporal, MD notified and ordered to send Resident #1 out to VA hospital. Contracted Ambulance Response notified at 1:00 p.m. --[DATE] at 2:15 p.m. - LVN M documented - Non rebreather mask applied to resident with O2 (Oxygen) at 15 liters, resident remains stable at this time, 911 arrived at 2:10 p.m., report given, resident still breathing. --[DATE] at 3:00 p.m. - LVN M documented - Addendum: Contracted transport ambulance refused to transport resident due to their assessment of resident which resulted in 911 being called. --[DATE] at 3:31 p.m. - LVN/UM documented a late entry for 2:20 p.m. - 911 in room performing Cardiopulmonary Resuscitation (CPR) on resident starting approximately 2:15 p.m. and [MEDICATION NAME] 15 minutes. Resident left via stretcher escorted by 911 staff. Family members at bedside, attending physician updated. During an interview with Physician #2 on [DATE] at 3:15 p.m. he said that initially he was called about Resident #15 and was told that the resident was not doing well and he ordered some blood work, urine test and chest x-ray. He said he received another call notifying him of the chest x-ray results and that they had not received the results of other blood work. The Physician initially said he believed the staff did what they were supposed to do. He said he talked to the staff at the hospital and they said the resident basically coded. He also said when he spoke with the Medical Examiner he told him he did not need an autopsy and that the body had been released to the funeral home. When asked to explain further, he said that Medical examiners look for wrong doing for an autopsy to be done. When asked if he left any parameters or guidelines as to when to be called he said no and that it was easier to just call him when they have any issues. When asked of the Physician if the facility notified him when Resident #15's O2 SAT dropped to 82% in the morning; when they could not get O2 SAT on him later that morning; when his BP dropped to ,[DATE] and when he became difficult to arouse upon verbal and tactile stimuli, he said he was not notified of those findings and did not know about the situation. When asked what he would have expected the facility to do in those situations, he said he would expect staff to call him immediately. During a confidential interview the person said that they were concerned about the amount of time it took for Resident #15 to receive medical attention including transporting the resident to the hospital. This person raised concerns about the facility in that they failed to call 911 earlier and felt that Resident #15 would still be alive if medical attention needed and transport by 911 were contacted. They said there was confusion during his time of need. He stayed at the facility for two hours instead of being transferred properly. During an interview on [DATE] at 1:45 p.m., LVN M said she was the desk nurse on the date of the incident, [DATE] and that as the desk nurse she was responsible for charting skin assessments, weekly notes, antibiotic charting, and getting paper work ready for resident appointments amongst other tasks. She said she knew what was happening when a visitor came to the desk and said she was Resident #15's visitor and his condition was not good and wanted to know what was happening. She also said RN AD was the floor nurse that had the resident. She further said she went to the room with RN AD to assess the resident and did vital signs on him as follows: BP ,[DATE], P 62, and Resp. ,[DATE] and could not get O2 reading. She said the resident did not respond to his name. She said RN AD left the room and came back and told her the resident was going to be sent out. At about 1:30 p.m. LVN M wrote the transfer order, and prepared transfer papers. She said she did not know what time the transportation was called but noted transport arrived about 1:50 p.m. She said that when transport arrived, they came to the desk and told her they could not transport Resident #15 because they did not have the proper equipment. She called the DON and she said to call 911. When 911 staff came most of the staff went to the room. She said she documented what she was asked to write by LVN/UM. When asked what she should do when a resident had a change in condition, she said assess the resident, obtain vital signs, call the MD, notify DON/RP, and follow MD orders. She said if a resident's condition became worse she would call 911 and notify the MD. LVN M was able to enumerate what to do when she got a new admission including assessment of skin and indwelling catheter - when it was inserted and how urine looks. She said she should get physician's orders [REDACTED]. During an interview on [DATE] at 3:30 p.m., LVN/UM said she was made aware by RN AD that Resident #15 had a temperature of 100.5 degrees Fahrenheit and she gave him Tylenol. She said they document vital signs on their nurse's notes and some on the Medication Administration Record [REDACTED]. She said she was on another hall when she learned about the resident's condition and on getting to the room [ROOM NUMBER] was already there doing CPR. She said the DON with other nurses were in the room. She said she knew the MD was notified of X-ray results but not when his O2 SAT dropped/vital signs. When asked what staff should do when a resident had a change in condition, said they should assess resident including getting vital signs and O2 SAT, call MD and RP and carry out MD orders. She also said others should be documented in the nurse's notes and on their SBAR. She said nurses should not administer medications/treatments without a physician's orders [REDACTED]. During an interview on [DATE] at 5:12 p.m., the DON when asked whether she knew Resident #15 had a change in condition and what happened, she said she knew he had a change in condition and was going to the hospital. She then said she received a call from the nurse that the transport company refused to transport Resident #15 because they could not get an O2 SAT reading on him. She said 911 was already called. She said when she got to the room the resident was still breathing, 911 staff came, checked and obtained his pulse, and then started bagging him and putting in an IV catheter. When the 911 staff came into the room, they intubated him and started CPR. She further said they worked on him for a while before taking him to the ER. When asked whether they should have called 911 instead of the ambulance transport service they use she said the staff had called the ambulance transport service because the resident was clinically stable. She also said when his O2 SAT dropped to 82% Oxygen was applied and he was always having high heart rate even on admission. She said she did not know staff could not get his O2 SAT at 1:17 p.m. as per the nurse's notes and did not know if vital signs were done between the hours of 11:21 a.m. and 1:17 p.m. She said there were many people in the room and thought vital signs were done during that time frame. Requested documentation of the vital signs/monitoring of the resident during the time frame, none was provided provided prior to exit on [DATE]. When the DON was asked if she conducted an investigation regarding the incident, she said yes and she felt anything that needed to be done was done. Surveyor requested for the investigation report. The DON left the room and returned about 10 minutes later and said she did not write the report unless the surveyor wanted her to go and write one then. During an interview on [DATE] at 10:00 a.m., the DON when asked who was responsible for making decisions as to whether to call 911 or call their contracted Ambulance service she said the Charge Nurse was the person to make the decision. If the condition worsened, the nurses could make the decisions and then notify her. She said she could update or change the decision if she was available. When asked if Resident #15's Physician had parameters or guidelines as to when staff should call him, she said no that only Resident #1's Physician had parameters. During an interview with the contracted ambulance transport dispatcher on [DATE] at 11:13 a.m., he said he received the call from Afton Oaks around 1:00 p.m. and when he asked the nurse the resident's status, she said Altered Mental Status and that it took staff about ½ hour to get to the facility. He said the staff that went to the facility said upon arrival, the nurse said the resident just got sick. They said that when they got to the room, the resident was breathing but they could not get his Oxygen Saturation on him with their machine. So, they advised them to call 911 and left. Requested for a copy of their run sheet. He said he would fax it. During a telephone interview on [DATE] at 12:20 p.m., RN AD acknowledged she had Resident #15 on the day shift on [DATE]. She said that when she made rounds that resident was talking and carried on conversation. She said she took the resident's vital signs between 9:00 a.m. and 9:30 a.m. and his O2 SAT was low. She said she notified her supervisor - LVN/UM, put him on O2 at 2 liters and notified Physician #2. She said resident had a temperature and was given Tylenol and Physician #2 was also notified and he ordered Stat laboratory tests, urine
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) Based on observation, interview, and record review the facility failed to ensure that 1 of 12 residents (Resident #6) reviewed for catheter care received appropriate treatment and services to reduce the risk of urinary tract infection in that: --CNA 57 failed to perform proper catheter care for Resident #6. This failure affected 1 resident and placed 11 other residents who had indwelling urinary catheter at risk of cross contamination, urinary tract infection, pain, and hospitalization . Findings include: Resident #6 Record review of Resident # 6's admission record revealed she was [AGE] years old and was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #6's Admission MDS assessment dated [DATE] revealed she had a Brief Interview of Mental Status BIMS score of 10 indicating she had moderate cognitive impairment. She required extensive to total assistance with Activities of Daily Living (ADLs) except for eating where she needed supervision. She had an indwelling catheter and a [MEDICAL CONDITION]. Record review of Resident #6's Care Plan dated 05/18/2017 revealed she was care planned for being dependent on staff to assist with ADLs, having an indwelling urinary catheter/at risk for developing urinary tract infections with intervention to perform catheter care every shift. Record review of Resident #6's laboratory result of urinalysis/culture and sensitivity collected on 07/18/2017 revealed a mixture of 3 or more organisms isolated indicative of probable contamination. No further testing was seen. Observation on 8/15/17 at 5:10 p.m. revealed Resident #6 laying in bed in her room. Resident was alert, oriented and conversant. Her indwelling catheter had yellow urine with sediment. Observation and interview on 8/21/17 at 12:28 p.m. revealed Resident #6 lying in bed in her room. She complained that staff were not cleaning her or her catheter and was wondering if they were supposed to clean her every day. Observation of indwelling catheter and catheter care for Resident #6 on 8/21/17 at 3:16 p.m. performed by CNA 57 and assisted by CNA 21 revealed the following: --Resident's mattress noted to have dirt all over mattress from wounds on her skin. CNA 57 asked Resident #6 who was her CNA for the morning shift and she said that it was CNA 27 that did not care for her or clean her up. -- CNA 57 and CNA 21 did not separate resident's legs in order to thoroughly clean the sides of the thigh and perineal area. -- CNA 57 did not hold Resident # 6's catheter at the meatus while cleaning the catheter. She wiped the catheter from insertion point outward away from the body without holding it to stabilize it in other not to pull it out. --CNA 57 also did not open Resident #6's labia to clean inside the labial skin folds around the opening to the urinary meatus. Vaginal area had an offensive odor and CNA 57 cleaned area several times until the last wipe was clear of dirt. Observation and interview on 8/22/17 at 9:35 a.m. revealed Resident #6 lying in bed in her room. She said that her day shift CNA 27 for 8/21/2017 did not clean her or perform catheter care on her. She also said she felt that CNA 57 pulled out her catheter because the catheter kept leaking urine most of the night and she reported this to her night nurse who then assessed, removed and changed the catheter. Record review of Resident #6's nurse's notes for 08/22/2017 at 1:52 a.m. revealed LVN G documented that resident complained of her indwelling catheter leaking urine and after assessment discovered urine around the catheter. LVN G documented she removed the catheter and later replaced it with a new one at 8:18 a.m. During an interview on 08/22/2017 at 3:55 p.m., CNA 57 was asked how she should clean the external vaginal area during incontinent/catheter care, she said she should have opened the resident's legs and labia and cleaned. When asked why she did not do that when cleaning Resident #6, she said she was nervous. On cleaning the catheter she said she should have held it to stabilize the catheter while cleaning and that she was nervous. When asked what the implication of not holding the catheter firmly during catheter care, she said she could have pulled the catheter out and the resident told her when she arrived to duty that the catheter was leaking most of the night and the nurse removed/changed the catheter. During an interview on 08/22/2017 at 4:20 p.m., the DON when asked what the implication of not holding the catheter to stabilize it while performing catheter care, she said it would be painful and the catheter could be pulled out. The DON was notified that one of her CNA's said that she signed catheter care sheets for other staff when she did not perform the catheter care, the DON said that whoever did the care should document it and that another CNA should not document care performed by another CNA. Record review of the facility policy and procedure entitled Care and Removal of an Indwelling Catheter, no date provided revealed: Providing regular perineal hygiene, preventing catheter related trauma, and removing indwelling catheters as soon as possible are important interventions to reduce the risk of catheter associated urinary tract infection The skill of performing routine catheter care can be delegated to nursing assistive personnel (NAP). The skill of removing an indwelling catheter can be delegated to NAP (see agency policy); however, the nurse must assess a patient's status and verify order. The nurse directs the NAP to: Report the condition of the urine (color, clarity, odor, and amount). Report the condition of the patient's genital area (e.g., color, rashes, open areas, odor, soiling from fecal incontinence, trauma to tissues around urinary meatus).Report patient complaints that might indicate a CAUTI: fever, chills, burning, flank pain, back pain, and blood in the urine The CMS 672 listed 12 residents who had indwelling urinary catheters.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the administration failed to administer the facility in a manner that enabled it to use the facility's resources effectively to maintain the highest practicable physical wellbeing of 2 of 18 residents (CR #1 and Resident #15) who were reviewed for administration of care in that: --The Administrator failed to effectively implement policies and procedures rearding abuse and neglect. --The Administrator failed to supervise the DON on training and monitoring nursing staff regarding assessment, monitoring and promptly consulting physicians concerning changes in condition. --The DON failed to train CNAs on notifying licensed staff on changes in condition. An immediate jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm that is not immediate jeopardy. The facility needed additional time to monitor and evaluate the effectiveness of their plan. This failure affected 1 hospitalized resident and 1 current resident and placed 11 other residents in the facility with indwelling urinary catheters at risk of injury, harm, urinary tract infections, hospitalization , and possible death. Intake # 7 and 2 Findings include: On [DATE] at 3:36 p.m. an interview with the Administrator when asked how he monitored to ensure the DON was performing her duties, his response was that he has the following procedures to make sure residents needs are met, the morning meeting, stand-up clinical, the 24 hour report and significant change of condition-ongoing, onset acute, then go into rehab to see if residents are progressing or not. He said they have QAPI to make sure things are going, management by walking around and having questions to all staff, this facility has a lot of RN's on staff because of their scope of knowledge from a quality point of view and in-services are ongoing. On [DATE] at 2:10 p.m. an interview with the DON revealed the following: when asked what type of training did you ensure the nurses had in order to care for residents, she said change in condition, pain, Foley care, abnormalities, transferring residents out of the facility, abuse/neglect, skin and sediments in catheters. When asked how did she think this IJ (immediate jeopardy came about, she said communication-verbally and written was dropped. She said to assure that job duties are being performed she will go behind staff to make sure the job is being done, if she notices any issues are there, they will re-educate to make sure training is effective, including demonstration and return demonstration with indescrepancies. Closed Record #1 Record review of CR #1's admission record revealed he was [AGE] years old and was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. He was discharged to the hospital on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 15) Record review of CR #1's Admission Nurse's notes by LVN U dated [DATE] revealed CR #1 was incontinent of bowel and bladder and there was no documentation of the presence of an indwelling urinary catheter. No other nurses' notes showed he had an indwelling catheter or that the catheter was changed through the time he was discharged . Record review of CR # 1's Admission Clinical Health Status note dated [DATE] documented his elimination and skin condition as follows: --Bladder: Incontinent. There was no documentation of him having an indwelling urinary catheter. The notes documented he was assessed as, incontinent of bowel and bladder. Record review of CR #1's Admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 5 indicating he had severely impaired cognition. He required extensive assistance for dressing, toilet use, and personal hygiene. He required total care with bathing. CR #1 needed supervision for eating and [DIAGNOSES REDACTED]. The MDS did not note the presence of his indwelling urinary catheter. His skin assessment revealed no pressure ulcer but that the resident was at risk of developing pressure ulcers. Record review of CR #1's Discharge MDS assessment dated [DATE] revealed no BIMS score documented. He required extensive assistance for dressing, toilet use, personal hygiene, and total care with bathing. CR #1 needed limited assistance for eating. Assessment of bowel and bladder revealed he was always incontinent of bowel and frequently incontinent of bladder. No skin assessment documented. Record review of Resident # 1's Care Plan for Activities of daily living (ADL) , not dated and not signed, had conflicting interventions. The intervention for bladder function revealed staff to assist resident as needed and record each shift whether he had voided. The same care plan had another intervention that stated resident had urinary catheter and directed staff to provide catheter care and record output. Record review of CR #1's unsigned physician's orders [REDACTED]. There were no admission orders [REDACTED] Record review of CR #1's Medication Admission Record dated July and [DATE] revealed no documented schedule or care for his indwelling urinary catheter. Record review of CR #1's Progress Notes for the month of [DATE] documented by the Nurse Practitioner (NP) for the Therapy department revealed as follows: --[DATE]: He was also complaining about pain in his 'privates.' --[DATE]: He wanted to know who was taking care of his privates now and he was told that the PCP (Primary Care Physician) at Afton was in charge. I discussed his problem with the ADON and she will talk to the patient about his concerns. He stated that other than his pain in his privates he felt ok. --[DATE]: The patient was still complaining about not understanding why he has a problem with his 'privates'. Per nursing, he only seems to complain about the catheter when I am present. Record review of CR#1's clinical record revealed no documentation of follow up care or physician notification. During an interview on [DATE] at 3:23 p.m. with the House Supervisor at the local hospital, she said her concern was that upon admission, CR #1's Foley catheter was dirty, his penis was filleted, it was open and he (Resident # 1) was septic. Record review of CR #1's medical records from the the local hospital obtained on [DATE] revealed he was admitted to the emergency room of the hospital on [DATE] at 13:22 p.m. and upon nursing assessment, it was noted, .Foley in place extremely dirty with sediments all along tube walls, patient's penis is split open from the bottom along the shaft. Urine dark brown It was also documented that CR #1 had [MEDICAL CONDITION] +2 to Right upper arm, right elbow, right forearm, left midcalf, left ankle, left upper arm, left elbow, left forearm, right midcalf and right ankle. Record review of the Physician's Progress Notes from the local hospital dated [DATE] at 9:55 p.m. revealed assessment and plan as follows: --Sepsis secondary to healthcare-associated pneumonia and urinary tract infection secondary to [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) and [MEDICATION NAME]. Urologist consult report from the local hospital dated [DATE] revealed as follows: --the patient noted on a thorough exam by ICU to have an indwelling Foley catheter for unknown reasons and found to have significant traumatic [DIAGNOSES REDACTED] from the Foley catheter. --the patient was previously admitted in the hospital in July and was discharged after a two-week stay to nursing home with a Foley catheter --Foley catheter presumed to be in place for likely [MEDICAL CONDITION] and there was no records found to document whether Foley catheter has been changed or not at the nursing home. The Urologist assessment revealed that the indwelling catheter was in place with approximately 5 cm of traumatic [DIAGNOSES REDACTED] and ventral erosion likely from Foley catheter and stated that the patient needs the Foley catheter to be exchanged and that he could benefit from a suprapubic tube in the future if he desires. Additionally, Nurses Shift Goals- Integumentary from the local hospital documented on [DATE] at 7:00 a.m. noted penile shaft open wound approx. ,[DATE] inch long, monitor s/sx (signs/symptoms) of infection. Observation and interview of CR #1 in his room at the local hospital on [DATE] at 10:59 a.m. with the hospital nurse and social worker present revealed he was alert and oriented to person and place. His right hand was swollen. He answered questions appropriately and coherently. CR #1 said, I will be [AGE] years old and never had something like this happen like this, someone cut it-someone cut it completely open down the shaft . He added the service he received at Afton Oaks was not good. He said, It looks like someone didn't like me, for some reason but I hadn't did anything to anyone, I don't want to go back there, my family member will take me home to (name of home State). CR #1 was in Isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his hospital nurse, she said it did not look like his catheter had been taken care of. She said there were old wounds to the front and lateral shaft. She said there was a large laceration on his penis draining pus and the meatus was sliced open, not healed, and with a pink bed to it. Observation of CR #1 in his room at the Medical Center on [DATE] at 8:15 a.m. revealed he was alert and oriented to person and place. His skin was dry with mild swelling to his extremities. He answered questions appropriately and coherently. CR #1 said he was butchered and sore. CR #1 remained on isolation for [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in his urine and [MEDICATION NAME]. Upon assessment by his nurse, it was noted that he had a severe cut from the tip of the penis along the shaft and down to the bottom of his penis with an open wound around the shaft and about 80% granulation tissue and 20% slough. He had no Pressure ulcer. CR #1 was still being treated with intravenous and oral antibiotics. The hospital nurse said they were treating the wound with wet to dry dressing changes. During an interview on [DATE] at 4:40 p.m., the Director of Nursing said that CR #1 was admitted into the facility with an indwelling catheter on [DATE]. When asked why his admission MDS assessment did not show documentation of the catheter, she said that she did not know. When asked about CR #1's wound assessment, the DON said his pressure ulcer was a stage 2 on his sacrum. She said that she did the resident's admission skin assessment in the presence of two other staff and that the wound was a stage 2 and it healed within three days. During an interview on [DATE] at 5:24 p.m. with CNA 57 in regards to CR #1 she was asked did she ever provide care for him and she answered, I don't remember, never took care of him. During an interview on [DATE] at 5:45 p.m., the DON said CR #1 was admitted from hospital with the catheter and that it was placed on [DATE] at the hospital. She also said the resident had the catheter placed due to [MEDICAL CONDITION] and [MEDICAL CONDITION] bladder. During an interview on [DATE] at 10:13 a.m. with LVN CE, she said in regards to CR #1 he used to sing and everything while doing his care. His right arm was swollen when he came. She said she would help the Treatment Nurse turn him. She said he had a Foley catheter. She said she knew she had taken care of him through the week but could not remember the day. She said his hand was hurting and she gave him a [MEDICATION NAME] and breathing treatment. She said he was sitting up in a chair. She said she could remember that when you got him out of bed, all he wanted to do was go back to bed and he liked to talk. During an interview on [DATE] at 11:00 a.m., the Treatment Nurse (RN AB) said CR #1 had intermittent confusion, his bottom and scrotum were intact. He had a Foley catheter. During an interview on [DATE] at 11:43 a.m. with CNA 31, she said she remembered CR #1. She said she was out for about 6 weeks and returned on the 7th of August. She said CR #1 was a real nice gentleman. She said he started going to the dining room, was taking therapy, and she would give him his showers on Monday, Wednesday and Friday. She said there were no concerns for him. She said he had a little red area on his buttocks and she documented it on the shower sheet and in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	**08/22/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	**7514 KINGSLEY ST HOUSTON, TX 77087**

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) couple of days the red area was gone. She said he was incontinent of both bowel and bladder, no Foley or ostomy, but could not really remember. During an interview on [DATE] at 11:51 a.m. with CNA 44, she said that CR #1 was nice, sweet, and that she helped him with everything, he asked, showers, and assist to chair. She said he was incontinent of bowel and bladder and had a urinary catheter. She said there were no problems or skin issues. During an interview on [DATE] at 12:00 p.m., the ADON when asked what she knew about CR #1, she said he was admitted during the middle of July, had an indwelling catheter, and [MEDICAL CONDITIONS] with [MEDICAL CONDITION]. She said the resident was cognitively confused intermittently and complained of pain to the Right shoulder. When asked whether she had any discussion with CR #1's Physician or NP's recently she said not that she could .remember or think of. When asked whether she had discussed with the Nurse Practitioner (NP) with the therapy department she said that Nurse Practitioner (NP) on one occasion said to her in a joking manner something about the resident's catheter and that he, CR #1, said he was going to call an Attorney. She said she did not know what the complaint was about and that it took place about 3 weeks prior. She also said she asked the nurses if CR #1 had complained to them about his catheter and they said no. When asked whether he was being given showers she said she had seen staff take him for showers. A request was made to review the resident's shower sheets from admission to his discharge. When asked if the NP discussed with her the Resident's complaint of pain of his privates she said she never discussed anything about that with her. She also said the resident had never complained to her or the staff about pain to his private area or with the catheter. When asked if she assessed the resident's catheter when the NP notified her of resident's complaints about his catheter, she said that she looked at the drainage bag and tubing and it was clean and she did not check the catheter or his penis because he was sitting in his chair. She said if the NP had told her about pain in the resident's private area she would have assessed the area and would have notified the DON and resident's Physician. During a telephone interview on [DATE] at 12:06 p.m., CNA 16 said that she worked at the facility PRN (as needed) and that she had taken care of CR #1. She said that he had a Foley catheter and sores in his private area, looks like he has a cut down there. When asked if she notified her nurse, she said she did not notify the nurse because the sores and cut looked like they had been there for a long time. She said she would have thought the nurses should have known and that as a PRN staff she had not worked since the last few weeks. She said that while cleaning him she had to be careful because it hurt him. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 16 took care of him on [DATE], [DATE], [DATE], [DATE] and [DATE]. Resident was sent to the hospital on [DATE]. Additionally, record review of the Catheter Output Roster revealed that from [DATE] (admitted) to [DATE] (discharge date) staff were documenting that Catheter care was provided each day as follows: [DATE] - 1 time [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 4 times [DATE] - 2 times [DATE] - 1 time [DATE] - 5 times [DATE] - 2 times [DATE] - 3 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 3 times [DATE] - 2 times [DATE] - 4 times [DATE] - 3 times [DATE] - 3 times [DATE] - 1 time [DATE] - 5 times [DATE] - 3 times [DATE] - 2 times No documentation from any staff reporting of CR #1 having wound to his penis and sediments in his urine. Record review of CR #1's Catheter Output Roster from [DATE] through [DATE] revealed that CNA 57 signed indicating she provided care for CR #1 on the following days: [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. During an interview on [DATE] at 2:47 p.m. with CNA 57, she was asked about caring for CR #1 again and was shown his picture from his medical record and where she had documented care, including Foley catheter care. She said she recalled care provided saying she never took care of his catheter but could remember feeding him. When asked why did she sign that all care was provided on her on behalf, she replied, that she went around asking other CNA's about their residents things like output and care and entered the information in the kiosk for them in order to keep it from going into red. She said she would go ask the CNA's how much a resident ate and would go report to the nurse if there was a change in condition. She said no one ever told her about a problem with CR #1's catheter or penis but if they did, they were supposed to report it to the nurse. During an interview on [DATE] at 12:50 p.m., the DON she said CR #1 was admitted to the facility with an indwelling catheter but could not remember whether it was changed or not and that best practice should be to document date /time when catheter/bag/ tubing was changed. She also said she did not receive any report and did not hear that he was complaining of pain in his private area. The DON said the implications of not assessing a resident's catheter could be possible retention of urine, and swelling in his pubic area and penis. When asked if staff doing catheter or incontinent care would have seen it if the resident had swelling, sores, and cuts, she said yes, they should have noticed that but if they did not report it nobody would know. Record review of CR #1's shower sheet for [DATE] and [DATE] revealed no documentation of any abnormal finding or wound to the resident's penis. There were no shower sheets for the other days from [DATE] to [DATE]. During a telephone interview on [DATE] at 3:50 p.m. with Physician A, he said he did not receive any calls from the facility regarding sores/cuts or wound on CR #1's penis and he was not notified about his having sediment in his urine. During an interview on [DATE] at 11:55 a.m., the NP for the therapy department said CR #1 had complained to her a couple of times that he was having pain in his privates anytime he saw her and he explained to her that the pain could be from his catheter. The NP said she checked with the nurses and they said he did not complain to them about pain in his catheter or his private area. She also said she had a discussion with the ADON regarding the resident's complaint of pain to his privates and asked for her to look into it and follow up with his Physician. When asked what she would usually do if she had any issues or complaints from any resident, she said she would notify nursing and if the resident's Physician was available, she would mention it to them. She said it was not in her role to assess resident's privates/penis but to notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	08/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	7514 KINGSLEY ST HOUSTON, TX 77087

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 17) nursing and she was not sure if he had any problem with his privates or that it was emergent and did not convey it to the ADON as if it was emergent. When asked when she started seeing CR #1, she said from [DATE] to [DATE]. During an interview on [DATE] at 11:25 a.m., the DON when asked whether a staff should document care another person performed, she said that catheter care was done by CNA's and nurses performed care of Suprapubic catheters. She said that whoever did the care should document it and that a CNA should not document care performed by another CNA. Resident #15 Record review of Resident #15's Admission record revealed he was [AGE] years old and was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #15's Admission MDS assessment dated [DATE] revealed he was assessed as having a BIMS score of 11 indicating moderately impaired cognition. He was totally dependent on staff for transfers, dressing, eating, toilet use, personal hygiene, and bathing. He needed the extensive assistance of staff with bed mobility. Record review of Resident #15's plan of care dated [DATE] revealed a plan of care for being at risk for complications related to Cardiac Pace Maker in place, at risk for impaired cardiovascular functions, staff assistance for all ADL's, full code, difficulty recalling recent events and use of indwelling suprapubic catheter due to [MEDICAL CONDITION] bladder and at risk for developing Urinary Tract Infections. Record review of Resident #15's Nurses notes for [DATE] revealed documentation of vital signs/status of resident (per nursing - time reflected was when nurses documented the vitals and not necessarily when the vitals were taken) as follows: --[DATE] at 6:25 a.m. - RN AA documented Resident #15's Temperature 100.5 degrees Fahrenheit, axillary. MD notified, STAT labs and Chest X-ray ordered. --[DATE] at 11:03 a.m. - LVN/Unit Manager (UM) documented that Chest X-ray result revealed left lower lobe increased opacity with consideration for pneumonia, atelectasis and pleural effusion. Notified attending Physician and awaiting response. --[DATE] at 11:21 a.m. - RN AD documented for vital signs taken at 9:00 a:m (per interview with RN AD on [DATE] at 12:20 p.m.): O2 Saturation (SAT) 82% on Room Air (RA), Respiration (Resp) 20, Pulse(P) 123 bpm; resident was put on Oxygen (O2) at 2 liters and Blood Pressure (BP) ,[DATE] mmHg; Physician/Responsible Party (RP) notified. --[DATE] at 11:30 a.m. - RN AD documented she noted the Suprapubic catheter was draining scant urine, MD notified with order to replace catheter, consent obtained from responsible party. --[DATE] at 1:17 p.m. - LVN M documented Resident was difficult to arouse upon verbal and tactile stimuli upon arrival of a visitor. Resp. (respirations) 14 bpm (breathes per minute) , BP (blood pressure) ,[DATE], P (pulse) 62 and no temp. (temperature) and no 02 SAT (oxygen saturation). --[DATE] at 1:32 p.m. - LVN M documented temp. 99 temporal, MD notified and ordered to send Resident #1 out to VA hospital. Contracted Ambulance Response notified at 1:00 p.m. --[DATE] at 2:15 p.m. - LVN M documented - Non rebreather mask applied to resident with O2 (Oxygen) at 15 liters, resident remains stable at this time, 911 arrived at 2:10 p.m., report given, resident still breathing. --[DATE] at 3:00 p.m. - LVN M documented - Addendum: Contracted transport ambulance refused to transport resident due to their assessment of resident which resulted in 911 being called. --[DATE] at 3:31 p.m. - LVN/UM documented a late entry for 2:20 p.m. - 911 in room performing Cardiopulmonary Resuscitation (CPR) on resident starting approximately 2:15 p.m. and [MEDICATION NAME] 15 minutes. Resident left via stretcher escorted by 911 staff. Family members at bedside, attending physician updated. During an interview with Physician #2 on [DATE] at 3:15 p.m. he said that initially he was called about Resident #15 and was told that the resident was not doing well and he ordered some blood work, urine test and chest x-ray. He said he received another call notifying him of the chest x-ray results and that they had not received the results of other blood work. The Physician initially said he believed the staff did what they were supposed to do. He said he talked to the staff at the hospital and they said the resident basically coded. He also said when he spoke with the Medical Examiner he told him he did not need an autopsy and that the body had been released to the funeral home. When asked to explain further, he said that Medical examiners look for wrong doing for an autopsy to be done. When asked if he left any parameters or guidelines as to when to be called he said no and that it was easier to just call him when they have any issues. When asked of the Physician if the facility notified him when Resident #15's O2 SAT dropped to 82% in the morning; when they could not get O2 SAT on him later that morning; when his BP dropped to ,[DATE] and when he became difficult to arouse upon verbal and tactile stimuli, he said he was not notified of those findings and did not know about the situation. When asked what he would have expected the facility to do in those situations, he said he would expect staff to call him immediately. During a confidential interview the person said that they were concerned about the amount of time it took for Resident #15 to receive medical attention including transporting the resident to the hospital. This person raised concerns about the facility in that they failed to call 911 earlier and felt that Resident #15 would still be alive if medical attention needed and transport by 911 were contacted. They said there was confusion during his time of need. He stayed at the facility for two hours instead of being transferred properly. During an interview on [DATE] at 1:45 p.m., LVN M said she was the desk nurse on the date of the incident, [DATE] and that as the desk nurse she was responsible for charting skin assessments, weekly notes, antibiotic charting, and getting paper work ready for resident appointments amongst other tasks. She said she knew what was happening when a visitor came to the desk and said she was Resident #15's visitor and his condition was not good and wanted to know what was happening. She also said RN AD was the floor nurse that had the resident. She further said she went to the room with RN AD to assess the resident and did vital signs on him as follows: BP ,[DATE], P 62, and Resp. ,[DATE] and could not get O2 reading. She said the resident did not respond to his name. She said RN AD left the room and came back and told her the resident was going to be sent out. At about 1:30 p.m. LVN M wrote the transfer order, and prepared transfer papers. She said she did not know what time the transportation was called but noted transport arrived about 1:50 p.m. She said that when transport arrived, they came to the desk and told her they could not transport Resident #15 because they did not have the proper equipment. She called the DON and she said to call 911. When 911 staff came most of the staff went to the room. She said she documented what she was asked to write by LVN/UM. When asked what she should do when a resident had a change in condition, she said assess the resident, obtain vital signs, call the MD, notify DON/RP, and follow MD orders. She said if a resident's condition became worse she would call 911 and notify the MD. LVN M was able to enumerate what to do when she got a new admission including assessment of skin and indwelling catheter - when it was inserted and how urine looks. She said she should get physician's orders [REDACTED]. During an interview on [DATE] at 3:30 p.m., LVN/UM said she was made aware by RN AD that Resident #15 had a temperature of 100.5 degrees Fahrenheit and she gave him Tylenol. She said they document vital signs on their nurse's notes and some on the Medication Administration Record [REDACTED]. She said she was on another hall when she learned about the resident's condition and on getting to the room [ROOM NUMBER] was already there doing CPR. She said the DON with other nurses were in the room. She said she knew the MD was notified of X-ray results but not when his O2 SAT dropped/vital signs. When asked what staff should do when a resident had a change in condition, said they should assess resident including getting vital signs and O2 SAT, call MD and RP and carry out MD orders. She also said others should be documented in the nurse's notes and on their SBAR. She said nurses should not administer medications/treatments without a physician's orders [REDACTED]. During an interview on [DATE] at 5:12 p.m., the DON when asked whether she knew Resident #15 had a change in condition and what happened, she said she knew he had a change in condition and was going to the hospital. She then said she received a call from the nurse that the transport company refused to transport Resident #15 because they could not get an O2 SAT reading on him. She said 911 was already called. She said when she got to the room the resident was still breathing, 911 staff came, checked and obtained his pulse, and then started bagging him and putting in an IV catheter. When the 911 staff came into the room, they intubated him and started CPR. She further said they worked on him for a while before taking him to the ER. When asked whether they should have called 911 instead of the ambulance transport service they use she said the staff had called the ambulance transport service because the resident was clinically stable. She also said when his O2 SAT dropped to 82% Oxygen was applied and he was always having high heart rate even on admission. She said she did not know staff could not get his O2 SAT at 1:17 p.m. as per the nurse's notes and did not know if vital signs were done between the hours of 11:21 a.m. and 1:17 p.m. She said there were many people in the room and thought vital signs were done during that time frame. Requested documentation of the vital signs/monitoring of the resident during the time frame, none was provided provided prior to exit on [DATE]. When the DON was asked if she conducted an investigation regarding the incident, she said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. BUILDING _____ B. WING _____	**08/22/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AFTON OAKS NURSING CENTER	**7514 KINGSLEY ST HOUSTON, TX 77087**

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 18) yes and she felt anything that needed to be done was done. Surveyor requested for the investigation report. The DON left the room and returned about 10 minutes later and said she did not write the report unless the surveyor wanted her to go and write one then. During an interview on [DATE] at 10:00 a.m., the DON when asked who was responsible for making decisions as to whether to call 911 or call their contracted Ambulance service she said the Charge Nurse was the person to make the decision. If the condition worsened, the nurses could make the decisions and then notify her. She said she could update or change the decision if she was available. When asked if Resident #15's Physician had parameters or guidelines as to when staff(TRUNCATED)