STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676273	A. BUILDING _____ B. WING _____	05/01/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK MANOR OF THE WOODLANDS	1014 WINDSOR LAKE BOULEVARD THE WOODLANDS, TX 77384

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 the responsible party when a significant change in physical condition occurred for 1 of 27 residents (Resident #34) reviewed for significant changes in physical condition. Resident #34 was readmitted to the facility on [DATE] with no pressures sores. Resident #34 developed a large left heel unstageable pressure ulcer first noted in physician's assessment dated [DATE]. Responsible party was not notified of the significant change in Resident # 34 's physical status. This affected one resident and placed 113 residents at risk for not having their responsible party notified when a significant change of physical condition exists which could result in a decline in their medical condition. Findings include: Record review of Resident # 34's face sheet revealed an [AGE] year old male admitted to the facility on [DATE]. Among his [DIAGNOSES REDACTED]. Record review of Resident # 34 's initial Minimum (MDS) data set [DATE] revealed Resident # 34 was not rated a high risk for development of pressure sores. Record review of Resident # 34's initial care plan dated 03/28/2015, revealed development of pressure sores was identified as an area of concern. Care plan dated 03/28/2015 did not detail specific preventative measures to help prevent Resident # 34 from developing pressure sores. Initial care plan was not updated after Resident # 34 was identified with a large left heel unstageable pressure sore on 04/11/2015. Record review of Resident # 34's initial Braden Scale for Predicting Pressure Ulcers dated March 17, 2015 revealed a Score of 12 (High Risk). Record review of Physician A's follow up visit note dated April 13, 2015 revealed a left heel pressure ulcer with eschar of 100%. Record review of Physician A 's treatment order dated 04/12/2015 revealed the following new treatment order .Clean L heel with normal saline,pat dry. Apply [MEDICATION NAME] to cover with gauze bandage roll q 3 days and PRN. Observation on 04/29/2015 at 8:50 AM of Resident # 34 's left heel wound during wound care revealed a large unstageable wound covering Resident 34 's entire left heel. In an interview with the UM on 04/30/2015 at 11:00 AM, she stated that she is not sure if the family of Resident #34 was notified of the significant change in Resident # 34 's physical status. In an interview with RN B on 04/29/2015, she stated that she has only been doing the wound care nurse position for about two weeks. She further stated that she does not think Resident # 34 's family was notified of the significant change in his physical condition due to his large left heel unstageable wound. RN B stated based on facility policy the responsible party should have been notified. In an interview with on 4/29/2015 at 11:45 AM with Resident # 34 's responsible party, he stated that he had not been informed of the significant change in Resident # 34 's physical condition due to the development of a large left heel unstageable pressure ulcer. He further stated that he did not know about Resident # 34 having a pressure ulcer. Record review of facility 's policy titled Prevention of Pressure Ulcers dated 2001 (revised March 2005) revealed .General Guidelines 6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. Review of the facility's policy titled Change in a Resident's Condition or Status, 2001 MED-PASS, INC. (Revised April 2007), read in part, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and /or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: a. A accident or incident involving the resident; b. A discovery of injuries of an unknown source: c. A reaction to medication; d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly;.3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when: .b. There is a significant change in the resident's physical, mental, or psychosocial status. Per CMS form 672 the facility census was 114.
F 0164 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep each resident's personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to provide privacy for 1 resident (Resident #61) observed during care. -LVN Z did not provide privacy when she gave Resident #61 an injection of sliding scale insulin. This deficient practice affected 1 resident and the potential to affect the additional 113 residents in the facility. Failure to provide personal privacy related to medical and emotional conditions could decrease resident's feelings and self-esteem. Findings included: Resident # 61 Record review of Resident # 61's facility medical record revealed she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Her diabetes was controlled by routine daily insulin and sliding scale insulin. She was [AGE] years old. An observation on 4/28/2015 at 3:45 PM of LVN Z taking Resident # 61's blood sugar with a glucometer revealed the LVN did not close the door or pull the curtain far enough around Resident 61's bed to provide complete privacy. Resident # 61 resided in the B bed (next to the window). The resident in A bed (next to the door) was present in the room at the time. Resident # 61 was observed sitting up in her wheelchair beside her bed talking to a family member. LVN Z entered the room at this time and explained to Resident # 61 what she was going to do, and Resident # 61 stuck up her left hand toward the LVN while continuing to converse with her visitor. LVN proceeded to prick the resident's finger to get the blood sample. She did not close the door to the room or pull the curtain around Resident # 61 to provide privacy. The family member remained in the room talking with Resident # 61.

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

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F 0164 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) LVN Z then exited the room and drew up the sliding scale insulin needed for the resident's blood glucose level of 202, which was 4 units of [MEDICATION NAME] Solution per injector pen. LVN Z then re-entered the room and pulled the curtain partially between the beds. Resident # 61 said in a surprised tone of voice, They don't usually do that and continued her conversation with her visitor. LVN Z asked Resident # 61 where she wanted the injection. Resident # 61 said she wanted it in the back of her left arm. LVN Z did not provide complete privacy while giving Resident # 61 her injection of insulin. There were 114 residents residing in the facility according to the daily census.
F 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try to resolve each resident's complaints quickly.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 (Resident # 3) of 27 residents reviewed for grievances. -Resident # 3 had been placed on contact isolation and told to remain in her room without sufficient evidence of the need for isolation. This failure affected 1 resident and placed 113 additional residents with a right to voice grievances at risk of decreased self-worth, dignity and unresolved concerns. Findings included: Resident #3 Record review of the Resident # 3's facility medical record revealed she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. An observation on 4/28/2015 at 9:00 AM during initial tour of the facility revealed she had contact isolation equipment next to her doorway. She was the only resident in the room. During an interview on 4/28/2015 at 12:14 PM with Resident # 3 in her room, she said that hardly anyone put on protective equipment. She said she was really mad about being in isolation. She said It has been a week and no one seems to know why I am still in isolation. I've had infections all my life since I had the car wreck when I was 15 and made a paraplegic. I came in with a wound vac. That was done with. Not everyone who comes in here wears protective equipment. I do my own [MEDICATION NAME] care. Sometimes the nurses do it. But I prefer to do it myself. I have been doing it a long time. I don't stay in my room like they want me to. I go all over. I just got back from the 300 hall where my friends are. She said she had complained to Everyone, and nothing got done. Record review of Resident # 3's facility lab urine culture results from 4/14/2015 read that the [DIAGNOSES REDACTED] pneumonia was greater than 100,000, however, because they were colonized (contained), the physician had written on the lab result sheet No need for isolation.has [MEDICATION NAME]. Record review of Resident # 3's facility medical record reflects several nurses notes indicating that nursing was aware she was coming in and out of her room at will. These notes reflected that on several occasions they would attempt to re-direct her back to her room. Record review of Resident # 3's Quarterly MDS assessment dated [DATE] coded her cognition as 15 out of a possible high 15. Resident # 3 was observed to be articulate and understanding of her illnesses. An observation of Resident # 3's room on 4/28/2015 at 4:40 PM revealed there was no evidence of isolation equipment in or near the room. During an interview at this time with Resident # 3 she said the staff just came and took it all away, not saying anything to her. She said I assumed my labs came back fine. Resident # 3 had been on contact isolation for one week. During an interview on 4/29/2015 at 12:15 PM with the DON she said that the isolation had been discontinued after talking to Resident # 3's physician and reviewing her laboratory results. Per CMS form 672, the facility census was 114.
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have evidence that all alleged violations are thoroughly investigated and that further potential abuse was prevented while the investigation was in progress for 1 of 27 residents reviewed for abuse/neglect (CR # 116). CR # 116 reported to the Administrator on 4/07/15 that he was physically and sexually abused on 4/03/15. The Administrator reported the allegation to the State on 4/09/15, but did not interview the staff on duty when the alleged incident occurred and did not conduct a thorough investigation. This failure affected 1 former resident and had the potential to affect all 114 residents currently residing in the facility by failing to comply with state laws and failing to protect residents from abuse, neglect, and/or exploitation. Findings include, Complaint # 4, Incident # 5 Record review of CR # 116's medical records revealed he was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. His [DIAGNOSES REDACTED]. He was [AGE] years old. Record review of CR # 116's admission MDS assessment dated [DATE] revealed he scored 3 of 15 possible correct answers on the BIMS (severe cognitive impairment). Under Section D0300 the Total Severity Score for the Resident Mood Interview was 8. Section E indicated no behaviors of any kind. Resident # 116 required extensive one person assistance for transfers and all ADLS except eating. He required only supervision for eating. He used a wheelchair for ambulation. He was always incontinent of bowel and bladder. Record review of the Provider Investigation Report revealed the incident occurred on 4/03/15 at 12:00 AM. The incident was reported to DADS on 4/09/15. The Description of the Allegation read, Resident informed Admin that he was attacked by 5 women in the facility and that they were led by the woman in charge of the kitchen. He then said that he made a deal with a taxi driver to get him out of the facility for $50, but the driver reneged on the deal. Resident said that if he didn't get released form the facility he'd go public with the info. The next morning the resident told our Social Worker that he was raped by 10 men and 10 women. He was interviewed by Admin again and said that 5 women in the kitchen raped him last Friday at midnight. He spoke with his son on the phone and his son told him it didn't happen and that they did not need that PR right now. Resident also stated that his son promised to get him out of the facility by 2 pm. Description of Assessment read, Resident refused assessment; however, he shows no signs of physical distress or injury. The Provider Response read, Resident's son notified. Son asked facility not to report or to document the allegation due to embarrassment. Son said he knows the allegation is not true. Administrator & SW discussed with son the need for placement in a psych hospital. Son initially expressed concern about costs associated with placement. Also expressed concern that his father would be upset with him because he was already upset that he was admitted into a skilled nursing facility. However, son agreed that placing his dad in psych hospital was best for his father . The Investigation Summary read, The allegation made by the resident changed numerous times through interviews and it was clear that the resident was not in touch with reality. He has been on on-to-one supervision during the time he claimed that he was attacked and/or raped. The kitchen is not open at midnight, nor is there staff in the kitchen during the night. The conclusion drawn by the Facility and the resident's family is that the allegation is unfounded. The Provider Action Taken Post-Investigation read that the resident was admitted to a psych hospital on [DATE]. There were no interviews with staff attached to the Investigation Report. Record review of CR # 116's nurse's notes revealed that notes from 3/31/15-4/06/15 no behavior problems at all were documented and no complaints at this time was repeatedly documented. On 4/07/15 at 6:30 PM a nurse's note documented a new order for [MEDICATION NAME] 0.5 mg, 1 tablet every 6 hours a day as needed for anxiety/agitation. On 4/07/15 at 10:22 PM a nurse's note read, increased restlessness. Remains on 1:1. Continues with increased anxiety. Med with prn as ordered. Tolerated well. Will continue to monitor. This note was the first entry found in CR # 116's medical records regarding 1:1 supervision. A nurse's note on 4/07/15 at 11:00 PM read, Belligerent with staff and cussing out staff when they are trying to assist him, has made several attempts to leave building even after instructed not to, gets upset with 1:1 staff, remains

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) with increased restlessness and frequent wandering/exit seeking, and when he is redirected per any staff member he then becomes irate, holds up hand as if he ' s going to hit staff, or is verbally abusive towards staff .resident finally laid down on couch in sitting area near door and went to sleep. Nurse notes documented the same behaviors on 4/08/15 and 4/09/15. In an interview with the Admin on 4/30/15 at 8:43 AM he stated CR # 116 admitted on Sunday, 3/29/15. He stated he was very agitated, wandered a great deal, made threats toward staff, and wanted to leave. He stated he urinated on the couch once. He stated that was probably an accident. Then another time he pulled his pants down in the living room and attempted to urinate on the couch, but staff managed to stop him. He stated CR # 116 became increasing combative and swung at staff with his fists. He stated CR # 116 was very angry at his son for admitting him into the facility. He stated, He thought he was in prison here. The Admin stated they placed him on 1:1. He stated he was not sure exactly when. He stated CR # 116 then approached him on Tuesday, 4/07/15 and told him that on Friday night, 4/03/15, he was attacked by 5 women. He stated 4/03/15 was Good Friday. He stated the next morning CR # 116 reported to the SW that he was attacked by 10 women and 10 men. He stated he was unable to determine that any incident had occurred. He stated CR # 116's son said he did not believe anything had happened and he did not want him to proceed with any investigation. He stated one of the sons worked for the Fire Dept. and they said they did not want the embarrassment of an investigation. He stated they transferred him to one psychiatric hospital, but CR # 116 was his own responsible party and refused to sign their paperwork so they would not admit him and he was returned to the facility. He stated they then sent him to a different psychiatric hospital and they admitted him. He stated the Sheriff's office came to the facility to inquire about the incident on 4/18/15. He stated he was not there when they came and the Sheriff interviewed the UM. An interview was conducted with CR # 116 over the telephone on 4/30/15 at 9:35 AM. He stated he didn't choose to go to the facility. He stated they put two people on him who stayed with him all of the time and he couldn ' t move around or do anything. He stated they wouldn't let him go outside and sit with other residents on the porch. He stated he stayed in the living room on the couch because he was afraid in the room they gave him. He stated then one night around 12:00-12:30 AM they took him back into the kitchen. He stated there were three staff - two women and one man. He stated they ripped his pants off, so he yelled rape and they stopped. He stated they told him he was a liability because he wouldn't do what he was told and they were going to show him what happens when you go against authority. He stated he did not know any names of the staff because they weren't wearing name tags. When asked for more details about how he was physically and sexually assaulted, CR # 116 did not give a response or give more specific details. He stated the next day a staff member gave him a t-shirt and sweat pants to put on since his pants were ripped up. CR # 116 stated his son checked him into a hospital and he was back at home now. He stated he filed a report with the [MEDICATION NAME] County Sheriff's Dept. when he came home from the hospital. CR # 116 had some confusion and had a little difficulty understanding questions over the telephone. In an interview with the Admin on 4/30/15 at 7:45 PM he stated when he checked CR # 116's file he found he doesn't have any witness statements from staff regarding the incident. He stated he interviewed a couple of CNA's who were doing 1:1 with CR # 116 and he interviewed the family. He stated he did not interview anyone who was working on the evening of 4/03/15. He stated he attempted to call CNA J, but he could not get ahold her on the phone. He stated the DON told him she was not on the schedule and they did not know if she was still working there. He stated he did not know who the charge nurse was on duty that night and he did not attempt to contact anyone else. He stated the family did not want him to pursue it. He stated everything he did was documented in his report to DADS. In an interview with the UM on 5/01/15 at 9:57 AM she stated the Sheriff's office came to the facility on [DATE] because CR # 116 had called them and reported abuse to them. She stated she was on call when they came. She stated the nurse called her and she spoke with the Sheriff over the telephone. She stated they could not reach the Admin. She stated she explained to the Officer the kind of behaviors CR # 116 had while in the facility. She stated the Officer said he would write up a report. She stated the Sheriff then left the facility and did not interview anyone else. She stated CR # 116 was very combative and kept trying to leave the facility. She stated she was not sure when they started 1:1 with him. In an interview with the SW on 5/01/15 at 10:18 AM she stated CR # 116 had a lot of aggressive and combative behaviors in the facility. She stated he would refuse to take his medications. She stated she talked to both of his sons on the phone. She stated they had to place him on constant 1:1. She stated she was not sure when the 1:1 was started. She stated CR # 116 came in to her office and reported to her that it was 10 women who physically and sexually attacked him. She stated he then changed it and stated it was 10 men who attacked him. She stated the son told her he knew it did not happen and he did not want to pursue it. She stated she told the son they still had to do their own investigation. The SW said the Admin took care of investigating the alleged abuse and she did not interview any staff about it. In an interview with the SW on 5/01/15 at 10:30 AM she stated she checked with the DON and they were not able to tell exactly when they began 1:1 with CR # 116. She stated the earliest documentation of 1:1 with him they found was on 4/07/15. In an interview with CNA K on 4/30/15 at 7:31 PM he stated he did 1:1 with CR # 116 on the 2:00-10:00 PM shift. He stated CR # 116 told him he was abused and he just said it was a bunch of women who did it. He stated CR # 116 was very combative and would yell at him and others. He stated he repeatedly wanted to go outside and he was always asking people for beer and cigarettes. In an interview with CNA L on 4/30/15 at 7:58 PM she stated she did 1:1 with CR # 116 all day on his last day in the facility. She stated after he got up he wanted to roam all over the facility and kept wanting to leave. She stated he seemed very confused. In an interview with the DM on 5/01/15 at 3:56 PM he stated he runs the kitchen. He stated he locks the doors to the kitchen at night when he leaves at 7:30 PM. He stated there is a spare key to the kitchen locked up in the facility somewhere for staff to get in the kitchen if there is an emergency, but he didn ' t know where it was kept. He stated there were several women who worked in the kitchen. He stated he did not know of who CR # 116 might have been referring to in his allegation. He stated he had not heard anything about CR # 116 alleging that staff took him into the kitchen at night and abused him. The DM stated no one had interviewed him or his staff or told him anything about it. Record review of a staff Assignment Sheet requested and provided shortly before exit from the facility for the 10:00 PM-6:00 AM shift dated 4/03/15 revealed there were two nurses and seven CNA ' s on duty that night. One of the CNA's was marked as a trainee. There were four men and five women working. Next to CNA J's name was written a ? and float/1:1 . A Surname that appeared to be another resident's name was written next to that and marked through. Contact information for only LVN H and CNA J was provided by the Administrator. Attempts were made to contact CNA J over the telephone on 5/01/15 at 3:43 PM and 5/04/15 at 8:31 AM and a voice mail message was left. CNA J did not return the calls. In an interview with LVN H on 5/04/15 at 8:15 AM she stated that she was the charge nurse on duty on the 10:00 PM-6:00 AM shift on 4/03/15. She stated she checked her notes and CR # 116 slept all night that night. She stated it was a quiet night and she didn't see anything unusual. She stated, I didn't have any incidents with (CR # 116) until a few days later after they put him on 1:1. She stated after they put him on 1:1 he became very combative and kept trying to leave. She stated a few days after that night someone asked her if she had any issues that night and she told them no. She stated she couldn't remember for sure who asked her that, but she did not think it was the Admin. She stated she was not asked any other questions or told anything about an allegation of abuse at that time. LVN H stated as time went on she heard different stories CR # 116 was telling people about that night. She stated she basically heard through the grapevine that he was alleging abuse that night. She stated the Admin did not interview her about it. Record review of the facility's policy titled Abuse Investigations read, All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management.The individual conducting the investigation will, as a minimum: .d. Interview any witnesses to the incident; .Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports. (Note: A copy of such reports must be attached to the Resident Abuse Investigation Report Form.). According to the facility's CMS Form 672 the census was 114.
F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide an ongoing activities program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being

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F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) for 1 of 27 residents reviewed for activities (Resident # 89). -Resident # 89 had her nails done twice and did not have any other In-Room activities conducted in the months of February, March, and April 2015. This deficient practice affected 1 resident and placed 2 additional residents who were bedfast at risk for isolation, low self-esteem, and a decline in mental status. Findings include: Record review of Resident # 89's medical records revealed she was admitted on [DATE] and had a readmission date of [DATE]. Her [DIAGNOSES REDACTED]. She was [AGE] years old. Record review of Resident # 89's MDS admission assessment dated [DATE] revealed her cognitive skills for daily decision making was assessed as severely impaired. She required extensive two person assistance for transfers and extensive one person assistance for all ADLS and was always incontinent of bowel and bladder. Music and baths were the two areas coded as very important to her on her activities assessment. Observations of Resident # 89 on 4/29/15 at 4:01 PM revealed she was in bed in her room and was awake. She observed to be unable to speak and did not make eye contact or respond when spoken to. In an interview with Resident # 89's family member on 4/30/15 at 8:16 AM she stated she comes every day of the week and spends the day with her. She stated Resident # 89 was bedfast and had been unable to speak for some time. The family member stated the AD used to come and do in-room activities with Resident # 89, but not anymore . She stated she had been massaging her and talking to her and trying to do things with her to stimulate her herself. In an interview with the AD on 4/30/15 at 10:16 AM she stated they did not stop doing in-room activities with Resident # 89 and they last saw her for activities on 4/29/15. Record review of the Individual In-Room Activity Program form used for Resident # 89 revealed nine different activity areas were listed at the top of the form with check boxes and a form on the bottom half to write in Date, Activity Presented, Response, Comments, Time Spent, and Signature. Activity areas listed were 1. Read to Resident, 2. Friendly Visit & Conversation 3. Play Music, 4. Play Cards & Games, 5. Sensory Stimulation, 6. Offer Snack & Beverage, 7. Physical Activity, 8. Video Movies, 9. Self Initiated (Books, puzzles, or needlework). The Response to Activity read, A. Verbalized Appreciation/Pleasure, B. Eye Contact, C. Positive/Calm Facial Expression, D. Actively Participated, E. Refused/Requested to Leave. Record review of Resident # 89's Individual In-Room Activity Program form for the months of February, March, and April 2015 revealed the following documentation: 2/04/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep - Time Spent: 1 min. 2/09/15 - Activity Presented: 2 (Friendly Visit & Conversation) - Response - B,C,D - Comments: Fixed her nails - Time Spent: 5 min. 2/15/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep - Time Spent: 1 min. 2/18/15- Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep/talked to her mother - Time Spent: 1 min. 2/23/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - B,C - Comments: Getting her Breathing Treat - Time Spent: 2 min. 3/02/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Getting treatment - Time Spent: 1 min. 3/04/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Not in room - Time Spent: 1 min. 3/06/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Watching TV - Time Spent: 1 min. 3/09/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - B,C - Comments: Watching TV/Had Company - Time Spent: 2 min. 3/11/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep - Time Spent: 1 min. 3/13/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - A,B,C - Comments: Watching TV/Had Company - Time Spent: 2 min. 3/16/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep - Time Spent: 1 min. 3/18/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep/Had Company - Time Spent: 1 min. 3/20/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep/Had Company - Time Spent: 1 min. 3/23/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep/Had Company - Time Spent: 1 min. 3/30/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: CNA working with her - Time Spent: 1 min. 4/08/15 - Activity Presented: left blank - Response - left blank- Comments: Talked to Mother - Time Spent: 10 min. 4/10/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Visited with her mom. Talked about (Resident # 89's) illness - Time Spent: 5 min. 4/13/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep - Time Spent: 1 min. 4/15/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Asleep/Mom in the room - Time Spent: 1 min. 4/29/15 - Activity Presented: 2. (Friendly Visit & Conversation) - Response - left blank- Comments: Trim Remove and replash (sic) her nails - Time Spent: 30 min. Record review of the activity notes in Resident # 89's electronic file revealed the last activity note was dated 1/29/15 and read, Resident is unable to make needs known. Resident ambulates with complete assistance. Have great support from family on a daily basis. We are going into room for social stimulation. We do touch, by lotioning hands, we talk to and we bring out to sit up front. Resident show facial expressions and that is how we communicate if Resident is enjoying or don't want to be bothered. According to the facility's CMS Form 672 there were 114 residents in the facility and 3 residents who were bedfast.
F 0273 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assess the resident when the resident enters the nursing home, in a timely manner.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct and complete a comprehensive assessment within 14 days after admission for 2 of 27 residents reviewed for comprehensive assessments (Residents # 31 and # 37). -Resident # 31 was admitted to the facility on [DATE] and the comprehensive admission assessment was not completed. -Resident # 37 was admitted to the facility on [DATE] and the comprehensive admission assessment was not completed. This failure affected 2 residents and placed an additional 112 residents at risk of having their plan of care developed based on inaccurate or incomplete information, and of funding being delayed or penalties imposed which could negatively impact resident care. Resident # 31 Record review of Resident # 31's medical records revealed she was admitted on [DATE]. Her [DIAGNOSES REDACTED]. She was [AGE] years old. Record review of Resident # 31's admission MDS assessment with ARD of 4/17/15 revealed it was listed in the electronic file as In Progress and only Section F (Preferences for Customary Routine and Activities) and Section L (Oral/Dental Status) were completed. Resident # 37

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	676273	A. BUILDING _____ B. WING _____	05/01/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK MANOR OF THE WOODLANDS	1014 WINDSOR LAKE BOULEVARD THE WOODLANDS, TX 77384

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F 0273 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Record review of Resident # 37's medical records revealed he was admitted on [DATE]. His [DIAGNOSES REDACTED]. He was [AGE] years old. Record review of Resident # 37's admission MDS assessment with ARD of 4/17/15 revealed it was listed in the electronic file as In Progress and the CAA was not completed. The assessment had not been signed by an RN as completed. In an interview conducted with MDS Nurse A on 4/30/15 at 3:45 PM she stated Resident # 31's admission assessment had not been completed. She did not give a reason why. MDS Nurse A stated Resident # 37's admission assessment was complete, but hasn't been transmitted. She stated an RN had not signed it. In an interview with the DON conducted at this time she stated Resident # 37's cognition triggered on the CAA and the CAA had to be closed out by the SW. She stated, I can't sign it as completed until they close it. All of the triggered areas have to be closed on the CAA. Record review of CMS's RAI Version 3.0 Manual CH 2: Assessments for the RAI dated April 2012, page 2-18, read in part, .The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: . the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. According to the facility's CMS Form 672 there were 114 residents in the facility.
F 0275 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Completely assess the resident at least every twelve months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a comprehensive assessment once every 12 months for 1 of 27 residents reviewed for comprehensive assessments (Resident # 110). -Resident # 110's last annual comprehensive MDS assessment had an ARD date of 4/13/2014. There were no other annual comprehensive MDS assessment in the resident's records. This failure affected one resident and placed an additional 113 residents at risk of having their plan of care developed based on inaccurate or incomplete information. Resident # 110 Record review of Resident # 110's medical records revealed she was admitted on [DATE]. Her [DIAGNOSES REDACTED]. The resident was [AGE] years old. Record review of Resident # 110's MDS assessments revealed an admission MDS assessment was completed on 4/15/2013. The next annual comprehensive MDS assessment was done on 4/13/2014. Further record review of the following annual comprehensive MDS assessment with ARD of 4/14/2015 revealed it was listed in the electronic file as In Progress and the CAA was not completed. The assessment had not been signed by an RN as completed. In an interview on 5/1/2015 at 4:00 PM with MDS Nurse A and MDS Nurse B, they were asked if they could find Resident #110 's annual MDS for 2015. MDS Nurse A said the annual MDS for 2015 was not complete due to sections of the CAA not being complete. However, she reported the MDS was MDS Nurse B 's responsibility to complete. MDS Nurse B said she thought Resident #110 's annual MDS for 2015 was already complete. After reviewing Resident 110 's annual MDS for 2015, MDS Nurse B said she had been recently hired, was still learning the system and will complete the MDS now. According to the facility's CMS 672 form there were 114 residents in the facility .
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and revise comprehensive care plans to meet the residents medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 27 residents (Resident # 3, # 34, # 37) reviewed for care plans. -Resident # 3 did not have a care plan regarding her [MEDICATION NAME] self care, or her isolation; -Resident # 34's care plan was not updated for pressure sores after Resident # 34 had acquired an unstageable left heel pressure ulcer and a deep tissue injury to the left great toe first documented on 04/12/2015. -Resident # 37 did not have a care plan for cognitive impairment, behaviors, or the administration of an anti-psychotic medication. This failure affected 3 residents and placed an additional 111 residents at risk for not having their medical care needs identified and addressed. Findings Include: Resident # 3 Record review of the Resident # 3's facility medical record revealed she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. An observation on 4/28/2015 at 9:00 AM during initial tour of the facility revealed she had contact isolation equipment next to her doorway. She was the only resident in the room. During an interview on 4/28/2015 at 12:14 PM with Resident # 3 in her room, she said that hardly anyone put on protective equipment. She said she was really mad about being in isolation. She said It had been a week and no one seems to know why I am still in isolation. I've had infections all my life since I had the car wreck when I was 15 and made a paraplegic. I came in with a wound vac. That was done with. Not everyone who comes in here wears protective equipment. I do my own [MEDICATION NAME] care. Sometimes the nurses do it. But I prefer to do it myself. I have been doing it a long time. I don't stay in my room like they want me to. I go all over. I just got back from the 300 hall where my friends are. No one has told me why I have to be on contact isolation. Record review of Resident # 3's facility medical record revealed several nurses notes indicating that nursing was aware she was coming in and out of her room at will. These notes reflected that on several occasions they would attempt to re-direct her back to her room. Record review of Resident # 3's Care Plan did not include any information regarding her [MEDICATION NAME] or an assessment that she was able to properly care for her own [MEDICATION NAME]. Continued record review of Resident #3's Care Plan did not have any information regarding contact isolation. Record review of Resident # 3's MDS dated [DATE] revealed she was checked under section O (Special Treatments.) for being in isolation or quarantine. An observation of Resident # 3's room on 4/28/2015 at 4:40 PM revealed there was no evidence of isolation equipment in or near the room. During an interview at this time with Resident # 3 she said the staff just came and took it all away, not saying anything to her. She said I assumed my labs came back fine. Resident # 3 had been on contact isolation for one week. During an interview on 4/30/2015 at 10:00 AM with the DON she said that the facility had called Resident # 3's physician and had received new orders to discontinue the contact isolation. She also said that there was a Care Plan developed for her [MEDICATION NAME] self-care and contact isolation. Record review on 5/01/2015 of Resident # 3's Care Plan revealed it had been updated on 4/30/2015 to include her [MEDICATION NAME] and self-care of it. There was also an updated nursing assessment note related to nursing staff having done an assessment on how Resident # 3 was able to properly care for her [MEDICATION NAME]. Resident # 34 Record review of Resident # 34's face sheet revealed an [AGE] year old male admitted to the facility on [DATE]. Among his [DIAGNOSES REDACTED]. Record review of Resident # 34 's care plan on 04/28/2015 revealed that the care plan had not been updated to properly reflect that Resident # 34 had developed a large unstageable pressure sore to his left heel and a deep tissue injury to his left great toe. Record review of Physician A order dated 04/12/2015, revealed physician ordered . Clean Left heel with normal salene and pat dry. Apply [MEDICATION NAME] to cover with gauze bandage roll . Apply [MEDICATION NAME] to Left great toe and leave open to air. In an interview on 05/01/2015 with Wound Care Nurse C he stated that the care plan on Resident # 34 had not been updated since the newly developed large left heel pressure ulcer on 04/12/2015. He also stated that the facility ' s current system

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) for reporting newly developed pressure sores is not really working. In an interview on 04/30/2015 with the UM at 11:00 AM, she stated that she was not informed until 04/29/2015 of the large left heel unstageable pressure ulcer which Resident # 34 had developed since his admission to the facility on [DATE]. She stated that Resident 34's care plan had not been updated to reflect this significant change. Resident # 37 Record review of Resident # 37's medical records revealed he was admitted on [DATE]. His [DIAGNOSES REDACTED]. He was [AGE] years old. Record review of Resident # 37's admission MDS assessment with ARD of 4/17/15 revealed his cognitive skills for daily decision making were coded a 2 - Moderately impaired. Record review of Resident # 37's April 2015 physician's Telephone Orders revealed an order dated 4/28/15 at 12:34 PM read, [MEDICATION NAME] IM injection 2 mg Q 4 hours for agitation. STAT. Under the Indication - DX column of the order was written increased agitation. Record review of Resident # 37's nurse's notes revealed the following entries: 4/27/2015 01:10 .Resident is yelling most of first part of shift. Up in wheelchair at nurses desk half of shift. Is disturbing residents on hall 200. Continues to be wakeful most nights . 4/28/2015 0138 .Resident is yelling most of shift. Up in wheel chair at nurses desk. Is disturbing residents on hall 200. Continues to be wakeful most nights. At nurses desk talking loudly and yelling . 4/28/2015 13:29 .Night nurse reported pt being up all night yelling. Patient observed yelling during the day with increased agitation. New orders from (Doctor) (oncall)/(MD B): [MEDICATION NAME] IM injections 2 mg 1 tab every 4 hours PRN for agitation . 4/28/2015 16:18 .Resident became highly agitated during attempt to administer medication. Will hold treatment for [REDACTED]. Record review of Resident # 37's Care Plan dated 4/22/15 revealed there was no care plan found for cognitive impairment, behaviors, or the administration of an anti-psychotic medication. Observation of Resident # 37 on 4/30/15 at 2:11 PM revealed he was awake, friendly, talkative, and calm. He was able to converse and interact to a limited extent and then he began talking excessively and rambling about events in the past. In an interview conducted with MDS Nurse A on 4/30/15 at 3:45 PM she stated she does the Care Plans for the residents. She stated Resident # 37 had a Care Plan. When MDS Nurse A was asked about the missing care plans for Resident # 37, she gave no response. Record review of the facility's policy Care Plans - Comprehensive, revised April 2010, read in part, . An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident 's condition change . According to CMS Form 672 the facility census was 114.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services in accordance with the plan of care for 1 of 27 residents (Resident # 89) reviewed for physician's orders [REDACTED]. -Resident # 89 was administered a different formula than was ordered by her physician. -Resident # 89's enteral nutrition feeding pump was turned off and on again and the head of the bed was lowered while the enteral feeding was infusing by CNA B during Resident # 89's incontinent care. This failure affected 1 resident and had the potential to place 7 other residents who had feedings by enteral nutrition feeding pumps at risk for not receiving adequate nutrition and services to meet their needs and could contribute to a decline in health status. The findings included: Record review of Resident # 89's medical records revealed she was admitted to the facility on [DATE] with a readmission date of [DATE]. Her [DIAGNOSES REDACTED]. She was [AGE] years old. In an observation of incontinence care on 04/28/2015, CNA B was observed turning off and on Resident 89 's enteral nutrition feeding pump and lowered the head of Resident # 89's bed while the enteral feeding was running. In an interview with CNA A on 05/01/2015 at 09:45 AM, she stated that facility policy does not allow a CNA to either turn on or off a feeding tube. She further stated that in orientation she was instructed that a nurse is the only employee who is allowed to turn feeding tubes either on or off. CNA #A stated that CNA #B should have asked a nurse to turn off and then on Resident 89 's enteral feeding during the performance of incontinence care on 04/28/2015. In an interview with ADON on 05/01/2015 at 02:55 PM, she stated that CNA 's are instructed in their orientation not to turn an enteral feeding pump on or off when providing care to a resident. Stated that CNA 's are trained to seek the assistance of a licensed nurse if an enteral feeding pump needs to be turned either on or off when performing care for a resident. She stated further she is not sure if this is detailed in the facility 's policies or if they simply follow best practices. Record review of Resident # 89 April 2015 physician 's orders revealed the following order, Give [MEDICATION NAME] 1.5 @ 60 cc/hr per [DEVICE] x 18 Hrs. Turn pump off 1 hour before/after [MEDICATION NAME] administration . Observation of Resident # 89 on 4/30/15 at 8:16 AM revealed [MEDICATION NAME] Renal 2.0 formula was hung on the [DEVICE] pump. The bottle read it had been hung on 4/29/15 at 4:02 PM. The pump was observed turned off at this time. In an interview with a family member in the room at this time she stated the pump was turned off because they had just administered [MEDICATION NAME] to Resident # 89. In an interview with the Unit Manager A on 5/01/15 at 9:57 AM she stated LVN X notified her that the wrong formula was hung on Resident # 89 's [DEVICE] after she removed it. She stated the family and physician were notified. She stated the 2-10 PM nurse the evening before had hung the wrong formula. She stated it was a mistake and she had written a medication error. Record review of a Medication Error Report revealed it read that the date and time of the error was 4/30/15 at 4:50 PM. Medication as ordered read, [MEDICATION NAME] 1.5 @ 60 ml/hr Description of error read, [MEDICATION NAME] hung/administered . Documentation on the Report read, Wrong formula immediately taken down, PEG ([DEVICE]) flushed, MD notified, family in rm (room), correct formula hung . A 1:1 in-service was conducted with the person making the error, LVN Y. Record review of facility's policy titled Enteral Nutrition detailed that .The dietitian and/or nursing staff will confirm or modify initial orders based on the complete nutritional assessment. Record review of the facility's CMS Form 672 revealed there were 8 residents who received feeding through the [DEVICE].
F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary care and services to prevent the development or worsening of pressure ulcers and to promote the healing of pressure ulcers for 4 of 11 residents (Resident #57, 34, 37, 3) who were reviewed for pressure ulcer care and management as evidenced by: - Resident # 57 who was assessed by the facility to be at high risk for developing pressure ulcers and entered the facility with sacral redness, developed multiple pressure ulcers including unstageable suspected deep tissue injuries to the sacrum and right heel, open areas bilaterally behind ears, and redness to abdomen. -Resident # 34 weekly skin assessement 4/11/15 documented a large unstageable pressure sore to the left heel on and a deep tissue injury to his left great toe. He did not have preventative pressure sore measures in his room including a heel lift and bilateral heel protectors until 04/30/2015. -Resident # 37 had a new wound to his right leg below the knee identified as an abrasion. -Resident # 3's wounds had not been measured and staged properly every week for the Sacral wound, left lateral knee, left

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 6) calf, left heel, left ankle and left buttock. This failure further resulted in an identification of an Immediate Jeopardy (IJ) 4/29/15 . While the IJ was removed on 05/01/2015, the facility remained out of compliance at the severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures affected 4 residents and placed 9 additional residents that were identified at risk for pressure ulcers at risk for a decline in health and need for additional treatment. Findings Include: Resident # 57 Record review of the medical record face sheet revealed Resident # 57 was originally admitted on [DATE] with a readmission date of [DATE]. [DIAGNOSES REDACTED]. He was [AGE] years old. He was discharged on the evening of 4/28/2015 to another facility. Record review dated 4/13/15 of Resident 57's Hospital Physician Discharge Summary revealed Resident skin color, texture normal, no rashes or [MEDICAL CONDITION]. Record review of Resident # 57's Admission MDS assessment with 3/5/2015 ARD date revealed he was readmitted to the facility on [DATE]. His Cognitive Skills for Daily Decision Making was assessed as moderately impaired. He was totally dependent and required one person assistance with bed mobility, transfers, eating, and toilet use. He required two or more person assistance with ambulation, dressing, and personal hygiene. He was assessed as having a range of motion impairment on one side of his upper and lower extremities. He had an indwelling urinary catheter and was always incontinent of bowel. The skin condition section of the assessment revealed he did not have a pressure ulcer and was not at risk of developing a pressure ulcer. Record review of Resident 57 's Interim Plan of Care dated 4/13/2015 revealed no documentation in the pressure sore section of the document. In the pressure ulcer risk section, documentation read inspect skin according to protocol. There were no specific interventions guidelines listed. Record review of Resident 57's Braden Scale - Predicting Pressure Score Risk revealed on 4/13/2015 his score was an 11 (high risk) and on 4/20/2015 his score was an 10 (high risk). Record review of Resident # 57's nurses notes, an Admission Summary dated 4/13/2015 and signed as written by LVN W read .Skin inspection unremarkable at this time some sacral redness present no active pressure sore, will continue to monitor. There were no measurements or further description noted. There was no documentation indicating if the physician or responsible party was notified of the sacral redness. Record review of Resident # 57 's nurses notes, a Health Status note dated 4/18/2015 signed by LVN A read, Skin breakdown to sacrum . On coming nurse informed of skin breakdown. There were no measurements or further description noted. Further record review of a Daily Skilled Nurse's note signed by LVN A dated 4/18/2015 read in part, .Skin breakdown noted to sacrum, covered with barrier cream wound care made aware. Record review of a Skin/Wound Note dated 4/19/2015 and signed by RN B describing the sacral pressure ulcer read, SDTI (suspected deep tissue injury) dark purple and black color with skin that has opened without depth . Right buttock measures 10.1 cm X 4.5 cm with central area of shearing measuring 5.0 cm X 4.0cm . Left buttock measures 3.5 cm X 4.0 cm. Heel pressure ulcer: Right heel exhibits SDTI measuring 2.5 cm X 3.0 cm and intact; prevalon boots intiated on 4/13/2015. Notes written on the report read, spoke to the CNAs about repositioning Resident # 57 side to side only and that the resident was on a low air loss mattress. Record review Resident # 57 's Wound Treatment and Progress record (found in the Wound Care binder) and signed by RN B dated 4/19/2013 revealed she documented that the sacral and heels pressure ulcers were unstageable and notified Resident # 57's responsible party. Further record review of the Wound Care Nurses binder revealed no documentation by LVN W regarding the redness found on Resident # 57's sacrum on admission. Record review of Resident # 57's care plan revealed the following care plans were updated on 4/17/2015: Keep family/responsible party and MD informed of residents progress. Assist with turning/repositioning every two hours and prn. Use padding between pressure areas and positioning devices for proper body alignment. Provide pressure relieving device for bed and chair. Record review of Resident # 57's Daily Skilled Nurses notes, Progress Notes and Assessment notes from the time of admission on 4/13/2015 to 4/18/2015 revealed no documentation of the condition of Resident # 57's skin, the presence of a low air loss mattress, or interventions being done to prevent the worsening of the redness found on his sacrum. Record review of Resident # 57's physician's orders revealed the following orders: Low air-loss mattress dated 4/17/2015. Cleanse open area sacrum/buttocks with NS (normal saline) pat dry, apply silicone gel dressing change Q 3 days (every three days) and PRN (as needed) dated 4/19/2015. Cleanse right heel with NS, pat dry, apply [MEDICATION NAME] dressing Q 3 days and PRN. Turn side to side only; prevalon boots BLE (bilateral lower extremities) dated 4/19/2015. Record review of a Health Status note dated 4/18/2015 and timed 5:31 pm, read in part, Open areas noted behind bilateral ears, dressing in place c/d/I (clean, dry, intact), red area to left mid abd (abdomen) noted . Healing sacral wound noted. An observation on 4/28/2015 at 4:00 pm revealed that Resident # 57 was in bed on an air mattress and had prevalon boots on both feet. He was positioned on his back with the head raised slightly. He was wearing a nasal cannula with gauze wrapped around the tubing behind his ears. The resident had a feeding tube and a Foley catheter in place. He was awake, but was unable to verbalize. His wife was at the bedside. In an interview done on 4/28/2015 at 4:00 pm with Resident # 57 's RP, she said she was aware of the redness on the resident sacrum on admission. However, upon observing his sacrum while RN B performed wound care on 4/24/2015, she found his sacral pressure ulcer had progressed. She said she had not been notified that the pressure ulcer had worsened from admission. Resident # 57's RP also reported earlier that day she found the PE[DEVICE] was pressed against his chest causing the development of persistent reddened areas on his chest. She notified a nurse who padded the tube in gauze. When asked how long Resident # 57 had been positioned on his back, she reported it had been about two and a half hours. She further reported he had developed a new pressure ulcer on this right heel since his readmission and that he has had the prevalon boots on since his admission. An observation on 4/29/2015 at 9:00 am revealed Resident # 57's bed was empty. The air mattress was still present but all other personal items were removed. In an interview done on 4/30/2015 at 9:30 am with Resident # 57's physician, he reported he was made aware of Resident # 57's pressure ulcers a few days after admission. In an interview with LVN A on 4/30/2015 at 9:45 am, he said on 4/18/2015 he noted the first layer of skin on Resident # 57's sacrum was broken and without bleeding or drainage. He further stated that he had not noted any skin breakdown on 4/16/2015 or 4/17/2015. When asked who he informed about the broken skin on the sacrum, he stated he called Resident # 57 's physician and notified the wound care nurse. In an interview with RN B, wound care nurse, conducted on 4/30/2015 at 11:30 am, she reported she became aware of Resident # 57's sacral pressure ulcer on 4/19/2015 upon reading other nurses notes in the computer. She then did her first assessment of Resident # 57's skin and recorded her findings in the computer and in the wound care binder. RN B stated she did not do skin assessments for new admissions and that it was the charge nurse's responsibility. She further said the charge nurse would notify her if any problems were found. During the interview RN B described Resident # 57's pressure ulcer as really red, dark purple with shearing to the superficial top layer of skin. She also stated there was no depth to measure. RN B also reported she found a small darkened area on his right heel with intact skin. She said she notified Resident # 57's responsible party and received treatment orders from Resident # 57's physician. RN B further stated she received her wound care training over three days from Wound Care Nurse C, who was a LVN. In an interview with LVN W on 4/30/2015 at 4:55pm, she said she assessed Resident # 57 on admission including a skin assessment. She described the area on Resident # 57's sacrum as very red with no skin breakdown. She further stated in order to communicate the redness to the wound care nurse, she wrote a note in the wound care nurses binder and also documented it in a nurses' note in the computer. LVN W said upon reading the notes, the wound care nurse would then assess for treatment and implement care plans. Record review of a Discharge Summary note dated 4/28/2015 revealed he was dicharged to a hospice facility. Resident # 34 Record review of Resident # 34's face sheet revealed an [AGE] year old male admitted to the facility on [DATE]. Among his

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) [DIAGNOSES REDACTED]. Record review of Resident # 34's annual Minimum Data Set completed on 04/07/2015 indicated in Section M that Resident # 34 was not at risk of developing pressure ulcers. Resident # 34's initial Brief Interview for Mental Status (BIMS) score was 06 out of a possible high 15 for cognitive status (severe impairment). Resident # 34 was identified as requiring extensive assistance/two persons with transfers and extensive assistance/one person with bed mobility. Record review of Resident # 34's initial care plan dated 03/28/2015, revealed development of pressure sores was identified as an area of concern. Care plan dated 03/28/2015 did not have specific preventative measures to help prevent Resident # 34 from developing pressure sores. Initial care plan was not updated after Resident # 34 was identified with a large left heel unstageable pressure sore on 04/11/2015. Record review of Resident # 34's medical record, the initial skin assessment Braden Score dated 03/17/15 was detailed as a 12 (High Risk) for development of pressure sores. In an observation on 04/28/2015 at 03:45 PM Resident # 34 was lying quietly in bed. Resident #34's feet were lying directly on his mattress. In an observation on 04/29/2015 at 08:50 AM Resident # 34 was lying quietly in bed. Resident # 34's feet were lying directly on his mattress. Resident # 34 was observed during wound care performed by RN B to have a very large unstageable pressure sore to his left heel and a deep tissue injury to his left great toe. RN B cleaned the wound with normal saline and applied [MEDICATION NAME] with a gauze bandage. In an interview with RN B on 04/30/2015 at 01:30 PM, she stated that she has only been in the wound care nurse role for about two weeks. She further stated that she was trained for a few days by Wound Care Nurse C. She stated that she did not actually have a skills check off as she had just shadowed Wound Care Nurse C. RN B stated her wound care training in the facility was minimal. Stated that Resident # 34's large left heel unstageable pressure sore was identified during weekly skin assessment rounds on 04/11/2015. Stated preventative pressure sore development measures should have been identified and put in place when Resident # 34 admitted to the facility on [DATE]. Stated that she can not locate any weekly skin assessments sheets on Resident # 34 prior to 04/11/2015. Stated she is not sure if weekly skin assessments were being performed. In an observation on 04/30/2015 at 08:35 AM, Resident # 34 was sitting up in his wheelchair. Resident # 34's bed was made with only a regular mattress in place. In an observation on 05/01/2015 at 08:50 AM, Resident # 34 was observed to not be in his room. Resident # 34's bed was observed to have a heel lift lying on top of his mattress. In an observation on 05/01/2015 at 09:20 AM, Resident # 34 was observed to be lying quietly in his bed. Resident # 34's feet were noted to have heel protectors which were resting on top of a heel lift. Record review of Resident # 34's weekly skin assessments dated 4/11/15, 04/18/15 and 04/25/15 revealed that Resident # 34 had a large unstageable heel pressure sore and a deep tissue injuiry to his left great toe. Record review of Resident #34's physician's telephone order dated 4/12/15 read in part, 1. apply [MEDICATION NAME] to left great toe and leave open to air every day and PRN. 2. Clean left heel with normal saline, pat dry, apply [MEDICATION NAME] and cover with dry gauze every 3 days and PRN. In an interview with Wound Care Nurse C on 05/01/2015 at 11:38 AM, he stated the facility does not really have a system in place as far as wound care is concerned. He further stated that the system in the facility is a failed system. He stated that a recently hired wound care nurse (RN B) shadowed him for a few days. He stated that he did not actually have RN B do a skills checkoff. He stated that he was not allowed to stage a wound. He stated that some of this facility's physicians do not want their residents to be followed by a wound care physician. He stated that the last time state surveyors were in the facility would care was identified as a problem. Wound Care Nurse C stated that he had not recently received any training on wound care. He stated that he could not recall the last time he had training on wound care. In interview with ADON on 05/01/2015 at 02:55 PM, she stated that she was not sure exactly who does the training for the wound care nurses in the facility. She further stated that the wound care nurses in the past she believes were trained by wound care nurses from other buildings. She also stated that she did not realize an LVN had recently trained an RN on wound care in the facility. The ADON stated that wound care nurses report directly to the DON. The ADON stated that she has no wound care background. In an interview with the DON on 05/01/2015 at 3:05 PM, she stated that RN B was trained by Wound Care Nurse C for a week. Stated that Wound Care Nurse C had been trained by Wound Care Nurse A. DON stated that she provides in service training on wound care to the facility's nurses. DON further stated that she does not have a background in wound care and she also stated that neither Wound Care Nurse C or RN B had not been checked off on their wound care skills. DON stated that preventative measures such as heel lifts, heel protectors, special mattresses, fluids at bedside, weekly skin assessments, and if appropriate a referral to the in house wound care physician should be immediately put into place once a resident is identified as high risk for development of pressure sores. She stated that since Resident # 34 had a initial Braden Score of 12 on admission to the facility on [DATE] he should have had preventative pressure sore measures identified and put into place. She stated that preventative pressure sore measures should have been re-evaluated on 04/12/2015 when the large left heel unstageable pressure sore was identified on Resident 34. In an interview with Corporate Nurse A on 05/01/2015 at 05:15 PM, she stated that she does not have special training in wound care. She stated that a Certified Woundcare Specialist (CWS) had been contacted to come to the facility immediately in order to provide comprehensive training to staff on wound care. In an interview with CWS A on 05/01/2015 at 05:50 PM, she stated that she was a Certified Woundcare Specialist (CWS). She stated that she had speciality training in wound care with the designation of CWS. She stated that she had been called by the facility to provide in depth wound care training for the facility staff. In an interview on 04/29/2015 at 11:45 AM with Resident # 34's responsible party, he stated he had not been informed of the significant change in Resident # 34's physical condition related to the development of a large left heel unstageable pressure ulcer and a deep tissue injury to the great left toe. He further stated that today (04/29/2015) is the first time he has heard about Resident # 34 having an unstageable pressure ulcer to his left heel. Resident # 37 Record review of Resident # 37's face sheet revealed a [AGE] year old male admitted to the facility on [DATE]. Among his [DIAGNOSES REDACTED]. Record review of Resident # 37's admission MDS assessment with ARD of 4/17/15 revealed his cognitive skills for daily decision making was coded a 2 - moderately impaired by staff assessment. He required extensive one person assistance for bed mobility, transfers, and all ADLS. He had one unstageable sacral pressure ulcer with slough.No measurement of the pressure ulcer was given in the assessment. Record review of Resident # 37's Care Plan dated 4/22/15 revealed a care plan for potential for pressure ulcer development r/t immobility. The goals were will have intact skin, free of redness, blisters or discoloration by/through review date. The Target Date was 7/12/15. The Interventions read, Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning.Monitor nutritional status. Serve diet as ordered, monitor intake and record.Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Record review of a Braden Scale for Predicting Pressure Sore Risk dated 4/10/15 revealed he was a Low Risk with a score of 18.0. Record review of a Braden Scale for Predicting Pressure Sore Risk dated 4/24/15 revealed he was a Low Risk with a score of 15.0. Record review of Resident # 37's Weekly Skin Integrity Review dated 4/11/15 revealed that he admitted to the facility with an unstageable sacrum pressure ulcer measuring 5.0 x 2.5 cm. Old open area, bruises, and redness were checked in the pressure ulcer assessment. Record review of Resident # 37's Weekly Skin Integrity Review dated 4/18/15 revealed an unstageable sacrum pressure ulcer measuring 5.0 x 2.5 cm. Documentation read, sacral unstageable, black/reddened, (missing word) below measuring 5.0 x 2.5 cm wound care ongoing. Record review of Resident # 37's Weekly Skin Integrity Review dated 4/25/15 revealed a Stage III sacrum pressure ulcer measuring 5.0 x 2.5 cm.

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 8) Record review of Resident # 37's physician's orders revealed an order dated 4/16/15 for liquid protein supplement, 30 cc two times a day for 30 days. Review of his April and May 2015 MARS revealed he was receiving the protein supplement twice a day at 8:00 AM and 4:00 PM as ordered. Further review of the physician's orders revealed a low air loss mattress was ordered on [DATE]. Observation of Resident # 37 on 4/29/15 at 4:23 PM revealed he was lying flat on his back in bed on a low air loss mattress. The resident was sleeping soundly. Record review of Resident # 37's progress notes revealed a skin/wound note dated 4/29/15 at 6:13 PM read, Overall skin evaluation, noted mushy right heel, blister to left knee, 3 small blisters to right shin, hydrogel dressing in place to sacrum with wound care ongoing. Left stump dressing clean/dry/intact. Spoke to (MD B) and received T.O.'s for [MEDICATION NAME] to blisters right shin & left knee with dressing QOD and [MEDICATION NAME] & leave OTA to right heel daily. Observation of Resident # 37 on 4/30/15 at 8:31 AM revealed he was lying flat on his back asleep on his bed. A water pitcher was sitting on the overbed table out of reach across the room beyond the foot of the bed. Observation of Resident # 37 on 4/30/15 at 2:11 PM revealed he was lying flat on his back on his bed awake. Resident # 37 was friendly and said hello. He was able to answer simple questions with mild confusion. He was observed to talk excessively, rambling about events in the past. In an observation of Resident # 37's wound care on 04/30/2015 at 09:15 AM, it was stated by RN B that Resident # 37 had a new wound to his right leg at the knee identified as an abrasion. The sacral wound was described by RN B as being a stage III with a very large newly developed excoriated area adjacent to the wound. In an interview with RN B on 04/30/2015 immediately afer performing wound care on Resident # 37 she stated that the large excoriated area next to the Stage III sacral wound was a change since April 28, 2015. She further stated that the reddened area with skin tear at the right knee was possibly a newly devloped pressure sore. Resident # 3 Record review of the Resident # 3's facility medical record revealed she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. Record review of Resident # 3's Quarterly MDS assessment dated [DATE] coded her cognition as 15 out of 15 possible correct answers on the BIMS. Continued record review of this same MDS dated [DATE] coded Resident # 3 as having 6 pressure ulcers with the worst as a Stage IV (to the bone). Resident # 3's admission MDS dated [DATE] coded the pressure ulcer as 6 unstageable pressure ulcers. Record review of Resident # 3's weekly skin review sheets dated from 2/17/15 read as follows: -2/17/2015 Right above knee amputation surgical site intact, multiple eschar (slough) to left lower extremity, sacral wound; -2/23/2015 Braden Scale skin assessment coded moderate risk of pressure ulcers; -2/24/2015, 3/03/2015, 3/10/2015,and 3/24/2015 all read Right above knee amputation surgical site healed, multiple eschar to left lower extremity, and sacral wound; -3/02/2015 Braden Scale skin assessment coded as low risk for receiving pressure sores; Weekly skin assessments for Resident # 3 continued as: -3/31/2015 Sacral wound, left lateral knee, left calf, left heel, left ankle; -4/07/2015 Left knee, left lower extremity, left heel, left buttock, left ankle; -4/14/2015 Old open area; -4/21/2015 Left heel pressure ulcer, unstageable, left lateral foot, left buttock pressure ulcer 4.1cm X 4.9cm X 1 cm. Sacrum pressure ulcer 1.2cm X 0.6cm. X 0.4cm. unstageable. Left lateral calf pressure ulcer 5.3cm X 0.9cm X 0.1cm. Left lateral knee pressure ulcer 1.5cm X 1.6cm X 0.2cm; -4/28/2015 Old open area left lateral foot scab, right buttock largest 1 cm - 2.1cm, right buttock vascular 3.3cm X 4.9cm X 0.5cm, left heel unstageable, left lateral knee pressure ulcer. During an interview on 4/28/2015 at 12:14 PM with Resident # 3 in her room, she said that hardly anyone put on protective equipment. She said she was really mad about being in isolation. She said It had been a week and no one seems to know why I am still in isolation. I've had infections all my life since I had the car wreck when I was 15 and made a paraplegic. I came in with a wound vac. That was done with. Not everyone who comes in here wears protective equipment. I do my own ostomy care. Sometimes the nurses do it. But I prefer to do it myself. I have been doing it a long time. I don't stay in my room like they want me to. I go all over. I just got back from the 300 hall where my friends are. In an interview and observation on 4/30/2015 at 1:45 PM with RN B providing wound care for Resident # 3, she stated she had been in the position for about 2 weeks. She said she felt very comfortable with doing wound care and had a long background in treating wounds. She said the wound specialist doctor does rounds on patients every Monday. She said that nearly all the wounds Resident # 3 had were unstageable because of the amount of eschar on them. She said the doctor was calling them Unstageable and was using collagen to pack the wounds. The wound on her was elongated and around the perimeter of the wound the skin was reddish pink color. RN B said the resident had [MEDICAL CONDITION] in the whole leg, according to the doctor. RN B proceeded to Resident # 3's coccyx pressure ulcer. The old dressing was saturation with old blood. RN B removed the old wound dressing which was much larger than the other wounds and quite deep, going into the muscle underneath the skin. The wound bed was moist and beefy red. There was no odor. RN B said that the doctor had called this wound unstageable also. She cleaned the wound with normal saline, patted it dry with 4 X 4 gauze pads, and wearing the same gloves re-dressed the wound. Another smaller area just below the large wound was observed to be open and bleeding. RN B said it was from taking the dressing on and off. She covered both areas with the same wound cover dressing. Record review of facility policy titled Prevention of Pressure Ulcers read in part .6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician and family, and addressed. Record review of the facility policy titled Pressure Ulcer Risk Assessment read in part . Steps in the Procedure . 4. Once risk factors have been identified, proceed to the Resident Assessment Protocols, care planning and interventions individualized for the resident and their particular risk factors. The facility Administrator was notified on 04/29/2015 at 11:25 AM that an IJ situation had been identified due to above failures. The Plan of Removal was submitted by the Administrator on 04/29/2014. The final Plan of Removal was accepted by the survey team on 05/01/2015 at 6:15 PM. Plan of Removal The facility submits the following Plan of Removal for the alleged failure to have an effective system in place to implement interventions to prevent wounds from developing and/or worsening. 1. Head to toe skin assessments on 100% of residents initiated on 4/29/15. Any residents with an issue identified during these assessments had interventions ordered and implemented on 4/29/15. The resident's physician and responsible parties were notified of the changes in condition. Resident care plans were updated to reflect interventions. Any residents with skin issues were referred to the Registered Dietitian if warranted. A communication to Rehab was also initiated for evaluation for positioning as warranted. a. 3 residents were identified with new or worsened pressure ulcers by the surveyors prior to the initiation of the IJ. The following is what was identified and what interventions were implemented for those 3 residents: a. Resident # 57 identified with a reddened area on his coccyx on 4/17/15. DTI to right heel identified on 4/19/15. Resident discharged on [DATE] to an inpatient hospice unit. b. Resident # 34 identified with an unstageable pressure ulcer to left heel on 4/12/15 . A DTI to the left great toe on 4/12/15. c. Resident #37 identified with Stage II to sacrum. Stage II to left knee on 4/30/15. b. During the 100% audit of head to toe skin assessments the following residents were identified with pressure ulcers: a. Resident #3 - admitted to facility on 2/11/15 with the following: Unstageable to sacrum. Unstageable to right buttocks. Unstageable to left heel. Unstageable to LL foot. Unstageable to left calf. Unstageable to left outer knee. b. Resident # 12 - Unstageable pressure ulcer to Left Lower Foot identified on 4/16/15. c. Resident # 69 - Stage II to left heel identified on 4/29/15. d. Resident # 78 - DTI to Right great toe identified on 4/13/15. e. Resident # 90 - Stage II mid spine identified on 4/29/15. f. Resident 100 - Stage II to left heel identified on 4/20/15. g. Resident # 102 - Stage II to sacrum identified on 4/23/15. 2. Skin concerns were placed on the 24 hour report to communicate changes in condition to Licensed Nurses in relation to wounds on 4/29/15. The 24 hour report is reviewed daily by the DON/designee and the nursing management team Monday - Friday

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 9) during the morning clinical meeting. 3. The C.N.A. 's received an in-service on 4/29/15, by RN J, on utilizing the Stop and Watch tool to report skin concerns. The Stop and Watch tool is a C.N.A. communication sheet used to identify changes in resident condition. The Stop and Watch tool will be turned into the Licensed Nurse at the time the change is noted and a copy of the tool will be given to the DON for follow up. 4. The Licensed Nurses were in-serviced, by RN J, on completing a head to toe skin assessment of residents upon admission on 4/30 and these assessments were initiated with all new admissions on 4/30/15. The treatment nurse/designee will perform a head to toe skin assessment after admission. The treatment nurse/designee will set the schedule for the weekly skin assessments beginning 4/30/15. The Director of Nurses and/or designee will monitor the treatment nurse and charge nurses to ensure system is followed. 5. The treatment nurse/designee will attend the morning clinical meeting held Monday through Friday, to report on findings of the skin assessments beginning on 4/30/15. The Nurse Management team will review for appropriate interventions. 6. The treatment nurse has been in-serviced by RN J and DON, on assessing pressure ulcers with each dressing change and notifying the physician of changes in the pressure ulcer, to include a deterioration of the pressure ulcer on 4/30/15. This in-service was repeated by the CWS on 5/1/15. The treatment nurse/designee will notify the physician and responsible party of the condition of pressure ulcers weekly beginning on 4/30/15. This in-servicing was completed on 4/30/15. 7. The Licensed Nurses and the C.N.A. 's were in-serviced by the nurse managers 4/30/15 on Pressure Ulcer Prevention. The Nurse Managers were in-serviced on 4/29/15 by the Vice President of Clinical Services. This in-service was repeated by the CWS on 5/1/15 with the DON. These measures included the following pressure ulcer prevention interventions: a. Turning and rep
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the resident environment remained as free of accident hazards as is possible as evidenced by, -Hot water temperatures in 12 resident bathrooms on the 300 hall ranged from 120-125 degrees Fahrenheit, and the hot water in the shower room on the 400 hall was 123.3 degrees Fahrenheit. This failure placed 59 residents residing on these halls (32 on the 300 hall and 27 on the 400 hall) at risk of scalding or burns which could result in pain and scarring. Findings include: Observations on initial tour of the facility on 4/28/15 from 8:45 AM - 10:35 AM revealed the following hot water temperatures were found in the resident bathrooms on hall 300: Room # 301 - 120 degrees Fahrenheit Room # 302 - 120 degrees Fahrenheit Room # 307 - 120 degrees Fahrenheit Room # 308 - 120 degrees Fahrenheit Room # 309 - 121 degrees Fahrenheit Room # 310 - 121 degrees Fahrenheit Room # 311 - 125 degrees Fahrenheit Room # 313 - 120 degrees Fahrenheit Room # 314 - 122 degrees Fahrenheit Room # 315 - 122 degrees Fahrenheit Room # 316 - 122 degrees Fahrenheit Room # 317 - 120 degrees Fahrenheit Observations on 4/28/15 at 12:08 PM revealed the following hot water temperatures were found in the resident bathrooms: Room # 301 - 122 degrees Fahrenheit Room # 304 - 123 degrees Fahrenheit Room # 315 - 118 degrees Fahrenheit Room # 316 - 122 degrees Fahrenheit Observations at this time revealed the following low hot water temperatures on the adjoining hall 400: Room # 402 - 80 degrees Fahrenheit Room # 404 - 80 degrees Fahrenheit Room # 405 - 98 degrees Fahrenheit Observations on 4/28/15 at 12: 45 PM revealed the following hot water temperatures obtained by the Maintenance Director using the facility 's thermometer: Room # 301 - 122.5 degrees Fahrenheit Room # 304 - 121.6 degrees Fahrenheit 400 hall shower room - 123.3 degrees Fahrenheit In an interview with Resident #62 on 4/28/15 at 12:15 PM when asked about the hot water he stated he just entered the facility yesterday and was not aware of any problems with the water. He stated he usually mix the hot and cold water together. In an interview with the Maintenance Director on 4/28/15 at 1:00 PM he stated he usually checks the water temperatures in two resident rooms on each hall each day. He stated they had a tankless hot water system. He stated one of the tankless hot water heaters that provided hot water to rooms on the 300 and 400 hall was malfunctioning and was causing high temperatures on the 300 hall and low temperatures on the 400 hall. He stated the contractor for the tankless hot water heaters came out on Thursday, 4/23/15 to look at it. He stated it needed a part and the part was ordered on [DATE] and would be in on Thursday or Friday, 4/30 - 5/01/15. He stated the Admin and DON knew they had a water problem on those halls. He stated he did not talk to the CNA's or the residents about it. Record review of the Water Temps log for the month of April 2015 revealed the water temperatures recorded from 4/20/15 - 4/24/15 for 10 rooms on 300 hall and 10 rooms on 400 hall was 108 degrees Fahrenheit for all. On 4/27/15 the water temperature recorded for room # 301 was 114 degrees Fahrenheit, room # 317 was 109 degrees Fahrenheit, and room # 401 - 109 degrees Fahrenheit, room 415 - 110 degrees Fahrenheit. In an interview with the Admin on 4/28/15 at 3:50 PM he stated the facility was going to conduct head to toe assessments on all residents residing on the 300 hall and the residents who use the 400 hall shower. A sign was placed on the 400 hall shower door. He stated the vendor they called the vendor and they came back to the facility. While at the facility the vendor looked around the maintenance director's office and noticed the replacement part for the hot water heater was in the office. He stated the problem should be fixed before the end of the day. Record review of the Resident Room Roster revealed 59 residents resided on the 300 and 400 halls (32 on the 300 hall and 27 on the 400 hall) .
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's to meet the needs of residents for 3 of 27 residents reviewed for pharmacy services (Resident #1, 84, and 57) --Resident # 1 received antihypertensive medications when ordered to hold for parameters; --Resident # 84 did not receive a routinely ordered medication during drug pass; -- Resident # 57 received antihypertensive medications when ordered to hold for parameters

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F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) This failure affected 3 residents and placed 111 residents at risk for not receiving the intended therapeutic benefits of their medications. Findings Include: Resident #1 Record review of Resident #1's face sheet revealed he was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. He was [AGE] years old. Record review of Resident #1's physician's monthly signed recap for April 2015 revealed an order that read lisinopril 5 mg, give 1 tablet via [DEVICE] one time a day for HTN (hypertension) Hold for SBP (systolic blood pressure) less than 105 and/or HR (heart rate) less than 55 with a start date of 2/19/2015. metoprolol tartrate tablet 25 mg give 1 tablet via [DEVICE] two times a day for HTN. Hold for SBP less than 105 and/or for HR less than 55. Start date 2/19/2015. Review of Resident #1's April 2015 Medication Administration Records (MARS) revealed- 4/2/15 blood pressure was 100/71 lisinopril 5 mg at 8:00 AM and metoprolol 25 mg at 8:00 AM was signed as given 4/6/15 blood pressure was 104/77 lisinopril 5 mg at 8:00 AM and metoprolol 25 mg at 8:00 AM was signed as given 4/8/15 blood pressure was 104/80 metoprolol 25 mg was signed as given at 4:00 PM 4/10/15 blood pressure was 58/44 metoprolol 25 mg was signed as given at 4:00 PM 4/17/15 blood pressure was 102/78 lisinopril 5 mg at 8:00 AM and metoprolol 25 mg at 8:00 AM was signed as given 4/20/15 blood pressure was 101/62 lisinopril 5 mg at 8:00 AM and metoprolol 25 mg at 8:00 AM was signed as given. In an interview on 5/1/15 at 10:30 AM the Director of Nurses (DON) said after they were informed of the errors they wrote a Medication Error Report and in-serviced the staff. Review of the Medication Error Report for Resident #1 revealed errors reports and in-services were written for the 4/6/15 administration of lisinopril and metoprolol and the 4/10/15 administration of metoprolol. Resident # 84 Record review of Resident # 84's facility medical record revealed she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. Observation on 4/28/2015 at 5:15 PM during a medication pass on Hall 300, MA A did not give Resident # 84 her Senokot (for constipation) at the 5:00 PM medication pass. During an interview with Resident # 84 on 4/29/2015 at 11:55 AM she said that she never takes the Senokot anymore. During an interview on 4/29/2015 at 12:00 PM with the DON she said she did not know that Resident # 84 had been refusing the Senokot and that she would speak to her about why she was not taking it anymore. During an interview on 4/29/2015 at 12:15 PM with the DON she said that she had spoken to Resident # 84 and the doctor would be notified with a new order for Senokot to be made PRN. During an interview on 4/29/2015 at 5:00 PM with MA A she said that Resident #84 always refuses that particular medication. She said she had not asked the resident if she wanted it or not. Resident # 57 Record review of the medical record face sheet revealed Resident # 57 was originally admitted on [DATE] with readmission date of [DATE]. [DIAGNOSES REDACTED]. He was [AGE] years old. He was discharged on the evening of 4/28/2015 to another facility. Record review of Resident # 57's physician's monthly signed recap for April 2015 revealed orders that read: Carvedilol 25 mg Give 1 tablet via [DEVICE] two times a day for HTN (hypertension) Hold for SBP (systolic blood pressure) less than 120 and heart rate less than 60. Lisinopril 5 mg give 1 tablet via [DEVICE] two times a day for HTN Hold for SBP less than 100. Both orders had a start date of 4/13/2015. Review of Resident #1's April 2015 Medication Administration Records (MARS) revealed- 4/19/2015-- blood pressure was 113/76, Carvedilol 25 mg at 9:00 AM was signed as given 4/20/2015-blood pressure was 98/56, Lisinopril 5 mg at 5:00 PM was signed as given 4/22/2015-blood pressure was 110/65, Carvedilol 25 mg at 5:00 PM was signed as given 4/24/2015-blood pressure was 100/65, Carvedilol 25 mg at 5:00 PM was signed as given During an interview on 4/29/2015 at 1:00 PM with the Corporate RN she said she was not aware that there were not blood pressure medication parameters for each resident. She said she would get a list of the residents who take blood pressure medications and investigate and call the physicians for a reason. In an interview on 5/1/15 at 3:00 PM the DON said after they were informed of the errors they wrote a Medication Error Report and in-serviced the staff. Review of the Medication Error Report for Resident #57 revealed errors reports and in-services were written for the 4/20/15 administration of Lisinopril and the 4/24/2015 and 4/19/2015 administration of carvedilol. Review of the facility's policy titled Administering Medications, 2001 MED-PASS, Inc (Revised March 2011) read in part, Medications shall be administered in a safe and timely manner and as prescribed. 4. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns.12. The individual administering the medication must initial the resident's MAR indicated [REDACTED]. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR indicated [REDACTED] According to the facility's CMS Form 672 there were 114 residents in the facility.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Infection Control Program provided a safe and sanitary environment to prevent the development of and transmission of disease and infections for 8 of 27 sampled residents (Resident # 3, # 46, # 71, # 34, #37, #89, #109, #110). The facility failed to follow its own infection control policy and procedure, as evidenced by: -Resident # 3 was told to remain in contact isolation with no justification from lab results; -RA A walked into a room requiring contact isolation without washing his hands or putting on PPE equipment and proceeded to prepare Resident #3's lunch tray, and did not wash his hands upon leaving the room.; -Wound care nurse C did not wash his hands upon re-entry to the room and prior to flushing Resident # 46's PE[DEVICE]. -LVN Y entered Resident # 71's room, did not wash her hands or put on gloves and proceeded to remove bed covers and the resident's socks to reveal her bare skin for a skin assessment. LVN Y did not wash her hands prior to leaving the room; -RN B did not follow proper infection control techniques when cleaning multiple wounds on Resident # 3; -RN B did not change her gloves after wiping a pressure sore area with normal saline and [MEDICATION NAME]. -RN B did not place tape over a resident's pressure sore dressing without her gloves on and labeling a resident's wound care dressing without her gloves on. -CNA A did not wash hands after performing incontinent care on Resident #37 prior to repositioning a resident up in his bed. -CNA's D and E did not wash their hands after performing incontinent care on resident #109 prior to repositioning a resident up in his bed. -CNA's F and G placed a resident 's soiled pants at the foot of the bed when performing incontinent care. These deficient practices affected 8 residents and had the potential to affect the 96 additional residents residing in the facility and could result in placing all residents and staff at risk for infections from cross-contamination. Findings included: Resident # 3 Record review of the Resident # 3's facility medical record revealed she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. An observation on 4/28/2015 at 9:00 AM during initial tour of the facility revealed she had contact isolation equipment next to her doorway. She was the only resident in the room. During an interview on 4/28/2015 at 09:00 AM with CNA C she said she did not know what kind of isolation Resident # 3 had.

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	676273	A. BUILDING _____ B. WING _____	**05/01/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) She said she thought it was for the urine. She said if she went in the room she would put on gloves, mask and a gown, and would wash her hands going in and leaving the room. During an interview on 4/28/2015 at 11:10 AM with CNA D she said she didn't know why Resident # 3 was in isolation, and that she would have to ask her charge nurse. She said she would gown, put on gloves and a mask. During an interview on 4/28/2015 at 12:14 PM with Resident # 3 in her room, she said that hardly anyone put on protective equipment. She said she was really mad about being in isolation. She said It had been a week and no one seems to know why I am still in isolation. I've had infections all my life since I had the car wreck when I was 15 and made a paraplegic. I came in with a wound vac. That was done with. Not everyone who comes in here wears protective equipment. I do my own ostomy care. Sometimes the nurses do it. But I prefer to do it myself. I have been doing it a long time. I don't stay in my room like they want me to. I go all over. I just got back from the 300 hall where my friends are. An observation on 4/28/2015 at12:25 PM of RA A bringing Resident # 3 her lunch tray. He put the tray on the over bed table and proceeded to unwrap the saran wrap from her drinks, cups, plates and cutlery. He did not wash his hands prior to coming into the room or when he left the room. An interview on 4/28/2015 at 12:55 PM with RA A he said he knew he forgot to wash his hands or put on PPE. He said he did not wash his hands when he left the room. He said I should have used the isolation equipment, washed my hands and gloves before I opened up her food and drink items. I forgot to wash my hands before I left the room. Record review of Resident # 3's facility medical record reflects several nurses notes indicating that nursing was aware she was coming in and out of her room at will. These notes reflected that on several occasions they would attempt to re-direct her back to her room. Continued record review of Resident # 3's medical record revealed urinary laboratory results showing [DIAGNOSES REDACTED] pneumonia was colonized, and contained. Record review of Resident # 3's Quarterly MDS assessment dated [DATE] coded her cognition as 15 out of a possible high 15. Resident # 3 was observed to be articulate and understanding of her illnesses. An observation of Resident # 3's room on 4/28/2015 at 4:40 PM revealed there was no evidence of isolation equipment in or near the room. During an interview at this time with Resident # 3 she said the staff just came and took it all away, not saying anything to her. She said I assumed my labs came back fine. Resident # 3 had been on contact isolation for one week. During an observation on 4/30/2015 at 1:45 PM of wound care for Resident # 3 performed by the new treatment nurse, RN B, revealed she did not wash hands prior to beginning to set up treatment supplies on the over bed table. She used a piece of wax paper and removed items from the drawers and set them on top of the wax paper with some item visibly touching the lap top and other items on the top of treatment cart. RN B took the treatment sheets off the treatment book into the room. She was observed to sanitize the end of the over bed table she was using as a clean field. She then placed gloves on and removed items from the bed getting ready to do wound care for Resident # 3. RN B gloved after washing her hands. She used 4 x4 gauze pads to clean around the site with normal saline she had just opened and poured into a plastic cup. Wound 1 was on the left lateral foot. It was open with reddish colored exudate. RN B said she only used skin prep on that area. RN B went on to the next wound located on resident's left lateral foot which has a light covering of light colored eschar. Using the same gloves RN B cleaned the wound and placed the clean dressing over it. She then washed her hands. started to remove the dressing to Resident #3's heel. The foot was placed on a clean 4 x 4 gauze pad on the bed. RN B said that she could wet the area on the heel with normal saline and it should come off. She said there was max oxide on the wound. Continued observation revealed the nurse did not clean the wound correctly and made a swiping movement on the wound. Then she patted the area dry and wearing the same gloves (now dirty) placed the wound cover over that wound. During an interview 4/30/2015 at 1:55 PM with RN B she stated she had been in the position for about 2 weeks. She said she felt very comfortable with doing wound care and had a long background in treating wounds. She said the wound specialist doctor did rounds on patients every Monday and made sure all the wounds were healing. She said that nearly all the wounds she had were unstageable because of the amount of eschar on them. Continued observation at this time of wound care for Resident # 3 by RN B revealed she washed her hands, donned gloved, and removed the outer dressing from the wound on the left upper leg. She said the doctor was calling it Unstageable and was using collagen to pack the wound. The wound was elongated and around the perimeter of the wound the skin was reddish pink color. RN B said the resident had DVT in the whole leg, according to the doctor. After the dirty dressing was removed, the nurse placed saturated 4 x 4 gauze pads with skin prep around the perimeter of the wound. She left the collagen in place and placed the clean dressing over the wound, wearing the same gloves. Continued observation of wound care at this time for Resident # 3 by RN B revealed she changed her gloves and washed her hands prior to starting wound care on the resident's coccyx pressure ulcer. The old dressing had dark saturation on it. RN B removed the old wound dressing which was much larger than the other wounds and quite deep, going into the muscle underneath the skin. The wound bed was moist and beefy red. There was no odor. RN B said that the doctor had called this wound unstageable also. She cleansed the wound with normal saline, patted it dry with 4 X 4 gauze pads, and wearing the same gloves re-dressed the wound. Another smaller area just below the large wound was observed to be open and bleeding. RN B said it was from taking the dressing on and off. An interview on 4/30/2015 at 2:45 PM with RN B revealed she had not been aware she had used the same gloves to clean the wounds and put on the clean dressings. She said I thought I was doing it right. Record review of Resident # 3's facility lab urine culture results from 4/14/2015 read that the [DIAGNOSES REDACTED] pneumonia was greater than 100,000, however, because they were colonized, the physician had written on the labs No need for colonization.has [MEDICATION NAME]. Resident # 46: Record review of Resident # 46's facility medical record revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. During an observation on 5/1/2015 at 10:40am of PE[DEVICE] flushing for Resident # 46 performed by Wound Care Nurse C revealed he did not wash his hands upon re-entry to the room and prior to beginning to set up supplies on the bedside table. He was observed to enter the room after retrieving a syringe and cup from another room. Upon re-entry, Wound Care Nurse C went to the bathroom and began to fill the cup with water. He then donned a pair of gloves and cleansed the top of the bedside table with a sanitizing wipe. Then he changed gloves and proceeded to check the placement, residual and flush Resident # 46 ' s PE[DEVICE]. Resident # 71 Record review of Resident # 71's facility medical record revealed she had been admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. She was [AGE] years old. On 5/01/2015 at 4:45 PM an interview was conducted with Resident # 71 in her room. She was in bed. She was clean and well groomed. There were no odors. She stated she did not have any feeling in either of her lower legs and wanted to know if there were any skin issues. An observation on 5/01/2015 at 5:00 PM of Resident # 71's feet was conducted by LVN Y. LVN Y walked into the resident's room and without washing hands she put on a pair of gloves and proceeded to remove the blankets and the resident's socks. Resident # 71 had a heel floatation device to prevent her heels from lying directly on the mattress. There was no break-down or redness noted on her feet. When LVN Y replaced the blankets she removed her gloves and walked out the room with them in her hands. She did not wash her hands first. When asked where she was going with them she said she was going to throw them away in the dirty utility room and would wash her hands there. When asked if this was what she usually did, LVN Y said that it depended on what she had been doing in the room. She said her hands had not been made dirty. Resident # 34 Record review of Resident # 34's face sheet revealed a [AGE] year old male admitted to the facility on [DATE]. Among his [DIAGNOSES REDACTED]. An observation on 04/29/2015 at 08:50 AM while performing wound care, revealed RN B did not wash her hands but did change her gloves after she had wiped Resident # 34's unstageable left heel wound with normal saline and [MEDICATION NAME]. RN B was observed placing tape on Resident # 34's unstageable left heel wound dressing without gloves during wound care. In an interview with RN B on 04/30/2015 at 01:30 PM she stated gloves should be worn when applying a dressing to a resident's pressure sore and when dating a dressing for a resident prior to application of the dressing on the resident. Resident # 37

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F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) Record review of Resident # 37 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE]. Among his [DIAGNOSES REDACTED]. An observation on 04/30/2015 at 09:15 AM, revealed RN B did not wear gloves when labeling Resident # 37's dressing for his sacral pressure sore. RN B and CNA A performed incontinent care on Resident # 37 soon after Resident # 37's sacral dressing had been applied. RN B was observed not wearing gloves while reinforcing Resident # 37's sacral dressing. An observation on 04/30/2015 at 09:25 AM revealed CNA A did not wash her hands or change her gloves after performing incontinent care on Resident # 37 just prior to assisting RN B reposition Resident # 37 up in bed. CNA A was also observed picking up a pillow off the floor after repositioning Resident # 37 up in bed without washing her hands or changing her gloves. In an interview with RN B on 04/30/2015 at 01:30 PM she stated gloves should be worn when applying a dressing to a resident ' s pressure sore and when dating a dressing for a resident prior to application of the dressing on the resident. In an interview with CNA A on 05/01/2015 at 09:45 AM, she stated that a CNA should remove their gloves and wash their hands after performing incontinent care prior to repositioning a resident in bed or picking up a resident's pillow off the floor. Resident # 89 Record review of Resident # 89's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] with a readmission date of [DATE]. Among her [DIAGNOSES REDACTED]. An observation on 04/28/2015 at 04:26 PM, revealed that CNA B when performing incontinent care placed the soiled sheet in a position in which it was touching the unsoiled sheet just prior to placing the unsoiled sheet in position under Resident # 89. Resident # 109 Record review of Resident # 109 ' s face sheet revealed a [AGE] year old female admitted to the facility on [DATE]. Among her [DIAGNOSES REDACTED]. In an observation on 04/29/2015 at 09:20 AM, CNAs D and E did not wash their hands or change their gloves after performing incontinent care prior to repositioning Resident # 109 up in her bed. In an interview with CNAs D and E on 04/29/2015 at 10:30 AM, when questioned both stated they were nervous and that they should have washed their hands and changed their gloves after performing incontinent care prior to repositioning Resident # 109 up in bed. Resident # 110 Record review of Resident # 110's face sheet revealed a [AGE] year old female admitted to the facility on [DATE]. Among her [DIAGNOSES REDACTED]. In an observation on 04/28/2015 at 04:00 PM, CNA's F and G removed Resident # 110's soiled pants and placed them on the foot of the bed when performing incontinent care. Resident # 110's clean pants were placed on top of the soiled pants just prior to assisting Resident # 110 with her clean pants. In an interview on 04/30/2015 at 3:30 PM, CNA F stated that Resident # 110 soiled pants should have been placed in the soiled laundry bag at the time of removal. She stated she knows this and was not sure as to why she contaminated Resident # 110 ' s clean pants at the time she was assisting Resident # 110 with her clean pants. In an interview on 05/01/2015 at 02:55 with the ADON, she stated that staff members performing care are trained to wash their hands after contact with soiled briefs, bedding, or personal clothing prior to assisting residents with clean briefs, bedding or personal clothing. She further stated that soiled items should not be placed on top of clean items. Record review of the facility's revised December 2011 Perineal Care read in part .Wash the perineal area, wiping from front to back .4. Gently dry perineum. *Avoid step 3 and 4 when using pre-moisten disposable wipes. C. Instruct or assist the resident to turn on her side .11. Discard disposable items into designated containers. 12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. 13. Put on clean gloves and place new brief and secure in place . Record review of the facility's policy and procedure revised December 2007 Standard Precautions, read in part, .Hand hygiene .d. Wash hands after removing gloves .Gloves .g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments . Record review of the facility's document titled Isolation - Categories of Transmission-Based Precautions, revised June 2010, under the section titled Contact Isolation read in part .In addition to Standard Precautions, implement Contact Precautions for resident known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Record review of the facility's policy and procedure titled Handwashing/Hand Hygiene, revised April 2010, read in part This facility considers hand hygiene the primary means to prevent the spread of infections .1) All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .3) Hand hygiene products and supplies shall be readily accessible and convenient for staff use to encourage compliance .5) Employees must wash their hands for at least fifteen seconds using antimicrobial or non-microbial soap and water under the following conditions: a) When coming on duty; b) when hands are visibly soiled; c) before and after direct resident contact .d) before and after any invasive procedure .e) before and after entering isolation precaution settings .f) before and after handling food .g) before and after assisting a resident with food .h) before and after assisting a resident with personal care . Per CMS form 672, the facility census was 114.
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 interview and record review the Administrator and DON failed to administer the facility in a manner that enables it to use its resources effectively and efficiently to ensure that residents who entered the facility without pressure ulcers did not develop pressure ulcers and residents with pressure ulcers received treatment and services to promote healing for 3 of 13 residents reviewed for pressure sores. (Residents # 57, 34 and 37) The Administrator failed to: --ensure the DON had skills and/or knowledge in training, supervising, and evaluating the wound care staff. --supervise the DON to ensure that nursing staff completed accurate pressure sore assessments and nursing staff was monitored to ensure preventive care was provided to residents at risk for skin breakdown. The DON failed to: --ensure the nursing staff were trained on identifying, reporting and documenting skin issues. --monitor and supervise the nursing staff on accurate pressure sore assessment, use of pressure relieving devices, and that preventive care was provided to residents at risk of skin breakdown. --ensure training were provided to the staff to include the Wound Treatment Nurse to be able to identify, measure and stage pressure sore accurately. --monitor nurses and CNAs on application of pressure reliving devices and following physician's orders [REDACTED]. This failure further resulted in an identification of an Immediate Jeopardy (IJ) on 04/29/2015 at 11:25 AM. While the IJ was removed on 05/01/2015 at 7:05 PM, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice had the potential to place 13 residents at risk for developing new or worsening pressure sores, deterioration of existing ones, pain, infection and hospitalization . Findings Include: In an interview on 05/01/2015 at 4:50 PM the Admin stated he was not aware of the situation before it was brought up to him. He stated Resident #34's situation got worse and the facility identified it too late. When asked, what procedures are there to make sure the residents needs are being met, he stated the treatment nurse will report to the morning meeting and report on all the wounds. The charge nurses will report on the halls. All the reports will be placed on the 24 hour report. Also to ensure that the nursing has the skills to do what they need to do. When asked, how will you ensure the systems the DON and ADON monitor are being done sufficiently, he stated by being part of the daily nursing meeting. Understanding what the

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) plan is and being involved in the process and if issues come up addressing them and being involved. Make resources available so that they can do the job they need to. When asked what resources they had available to them, he stated he explained the situation to the Medical Director. The Medical Director though the plan of removal was good. They facility has their sister facility's and the corporate staff and vendors to provide training as needed. In an interview with the DON on 05/01/2015 at 3:05 PM, she stated that she provides in service training on wound care to the facility's nurses. DON further stated that she does not have a background in wound care and she also stated that neither Wound Care Nurse B or RN B had not been checked off on their wound care skills. When asked how do you think the incident came about, she stated the resident has a pressures sores that developed in house. The facility did not take wound measurements, install preventative measures such as heel lifts, heel protectors, special mattresses or perform weekly skin assessments. In an interview with Corporate Nurse A on 05/01/2015 at 05:15 PM, she stated that she does not have special training in wound care. She stated that a Certified Woundcare Specialist (CWS) had been contacted to come to the facility immediately in order to provide comprehensive training to staff on wound care. In an interview with CWS A on 05/01/2015 at 05:50 PM, she stated that she was a Certified Woundcare Specialist (CWS). She stated that she had speciality training in wound care with the designation of CWS. She stated that she had been called by the facility to provide in depth wound care training for the facility staff. Resident # 57 admitted to the facility on [DATE]. His admission MDS assessment dated [DATE] indicated he did not have any pressure ulcers and was not at risk for developing pressure ulcers. He was identified on two Braden Scale assessments conducted by the facility as being a high risk for pressure ulcers and had sacral redness identified on admission. He developed multiple pressure ulcers including unstageable suspected deep tissue injuries to the sacrum and right heel, open areas bilaterally behind ears, and redness to the abdomen. Resident # 34 admitted to the facility on [DATE] with no pressure ulcers. The Admission MDS assessment dated [DATE] indicated he was not at risk for developing pressure ulcers. The Braden Scale initial assessment score was 12 - High Risk. Resident # 34 developed a large unstageable pressure sore to the left heel identified on 04/12/2015. Preventative pressure sore interventions including a heel lift and bilateral heel protectors were not put into place until 04/30/2015. Resident # 37 had one sacral pressure ulcer when admitted to the facility on [DATE], but was identified as low risk for pressure ulcers on two Braden Scale assessments conducted by the facility. Three skin assessments done by the facility did not identify any new areas. A skin assessment conducted on 4/29/15 after the IJ was called revealed a mushy right heal, a blister to the left knee, and three small blisters to the right shin. Observations of wound care on 4/30/15 revealed a new wound to Resident # 37 ' s right leg, below the knee. The facility Administrator was notified on 04/29/2015 at 11:25 AM that an IJ situation had been identified due to above failures. The following Plan of Removal was submitted by the Administrator on 04/29/2014. The final Plan of Removal was accepted by the survey team on 05/01/2015 at 6:15 PM. Plan of Removal The facility submits the following Plan of Removal for the alleged failure to have an effective system in place to implement interventions to prevent wounds from developing and/or worsening. 1. Head to toe skin assessments on 100% of residents initiated on 4/29/15. Any residents with an issue identified during these assessments had interventions ordered and implemented on 4/29/15. The resident's physician and responsible parties were notified of the changes in condition. Resident care plans were updated to reflect interventions. Any residents with skin issues were referred to the Registered Dietitian if warranted. A communication to Rehab was also initiated for evaluation for positioning as warranted. a. 3 residents were identified with new or worsened pressure ulcers by the surveyors prior to the initiation of the IJ. The following is what was identified and what interventions were implemented for those 3 residents: a. Resident # 57 identified with a reddened area on his coccyx on 4/17/15. DTI to right heel identified on 4/19/15. Resident discharged on [DATE] to an inpatient hospice unit. b. Resident # 34 identified with an unstageable pressure ulcer to left heel on 4/12/15 . A DTI to the left great toe on 4/12/15. c. Resident #37 identified with Stage II to sacrum. Stage II to left knee on 4/30/15. b. During the 100% audit of head to toe skin assessments the following residents were identified with pressure ulcers: a. Resident #3 - admitted to facility on 2/11/15 with the following: Unstageable to sacrum. Unstageable to right buttocks. Unstageable to left heel. Unstageable to LL foot. Unstageable to left calf. Unstageable to left outer knee. b. Resident # 12 - Unstageable pressure ulcer to Left Lower Foot identified on 4/16/15. c. Resident # 69 - Stage II to left heel identified on 4/29/15. d. Resident # 78 - DTI to Right great toe identified on 4/13/15. e. Resident # 90 - Stage II mid spine identified on 4/29/15. f. Resident 100 - Stage II to left heel identified on 4/20/15. g. Resident # 102 - Stage II to sacrum identified on 4/23/15. 2. Skin concerns were placed on the 24 hour report to communicate changes in condition to Licensed Nurses in relation to wounds on 4/29/15. The 24 hour report is reviewed daily by the DON/designee and the nursing management team Monday - Friday during the morning clinical meeting. 3. The C.N.A. 's received an in-service on 4/29/15, by RN J, on utilizing the Stop and Watch tool to report skin concerns. The Stop and Watch tool is a C.N.A. communication sheet used to identify changes in resident condition. The Stop and Watch tool will be turned into the Licensed Nurse at the time the change is noted and a copy of the tool will be given to the DON for follow up. 4. The Licensed Nurses were in-serviced, by RN J, on completing a head to toe skin assessment of residents upon admission on 4/30 and these assessments were initiated with all new admissions on 4/30/15. The treatment nurse/designee will perform a head to toe skin assessment after admission. The treatment nurse/designee will set the schedule for the weekly skin assessments beginning 4/30/15. The Director of Nurses and/or designee will monitor the treatment nurse and charge nurses to ensure system is followed. 5. The treatment nurse/designee will attend the morning clinical meeting held Monday through Friday, to report on findings of the skin assessments beginning on 4/30/15. The Nurse Management team will review for appropriate interventions. 6. The treatment nurse has been in-serviced by RN J and DON, on assessing pressure ulcers with each dressing change and notifying the physician of changes in the pressure ulcer, to include a deterioration of the pressure ulcer on 4/30/15. This in-service was repeated by the CWS on 5/1/15. The treatment nurse/designee will notify the physician and responsible party of the condition of pressure ulcers weekly beginning on 4/30/15. This in-servicing was completed on 4/30/15. 7. The Licensed Nurses and the C.N.A. 's were in-serviced by the nurse managers 4/30/15 on Pressure Ulcer Prevention. The Nurse Managers were in-serviced on 4/29/15 by the Vice President of Clinical Services. This in-service was repeated by the CWS on 5/1/15 with the DON. These measures included the following pressure ulcer prevention interventions: a. Turning and repositioning b. Pressure reducing devices in bed and/or chair such as cushions, pressure reducing mattresses, low air loss mattresses, heel floats, etc. c. Reducing friction and shear by lifting during repositioning d. Active and Passive Range of Motion e. Referral to rehab services for positioning f. Referral to Dietitian for nutritional support recommendations g. Encouraging nutritional and hydration intake h. Using moisture barriers for incontinent residents i. Avoiding skin to skin contact j. Protect bony prominence's as needed. 8. The Director of Nurses and/or designee will train all new hires (CNA 's and Licensed Nurses) upon employment at the facility. 9. The facility Medical Director was notified of the Immediate Jeopardy on 4/30/15 related to pressure ulcers and an impromptu QAPI meeting was held. The Medical Director has approved this plan. The survey team monitored the current plan of removal as follows: Reviewed interventions for Resident's # 34 as per stated in plan of removal. All interventions were initiated and carried out. Resident # 37 had a re-assessment of his wounds and new physician orders [REDACTED]. Resident # 57 transferred to a hospice facility. The facility conducted head to toe skin assessment on the residents currently residing in the facility. Skin concerns were addressed immediately. Completion date 4/30/15. Skin concerns were placed on the 24 hour report by hall to communicate to the charge nurses, residents with wounds when documenting daily skilled nurses notes. Completion date 4/29/15 and ongoing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676273	A. BUILDING _____ B. WING _____	05/01/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK MANOR OF THE WOODLANDS	1014 WINDSOR LAKE BOULEVARD THE WOODLANDS, TX 77384

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 14) The CNA's received in-service on 4/29/15 on utilizing the Stop and Watch tool to report skin concerns. Completion date 4/29/15. The licensed nurses and CNA's were in-serviced on pressure ulcer prevention for all shift. Completion date 4/30/15. The licensed Nurses were in-serviced on completing head to toe skin assessments. Completion date 4/30/15. The treatment nurse were in-serviced on assessing pressure ulcers, physician notification, deterioration of the pressure ulcer. Completion date 4/30/15. All in-service documentation was reviewed and attendance checked to ensure all licensed nurses were in-serviced. Completion date 4/30/15. Interviews conducted on 05/01/2015 with licensed nursing staff reflected the nurses knew how to appropriately identify, stage, treat and prevent pressure sores. Interviews conducted on 05/01/2015 with certified nursing aides reflected the CNA's knew how to report changes in resident skin, and how to monitor for changes in resident skin. On 05/01/2015 at 7:05 PM the facility Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility provided a list of 13 residents at risk for pressure sores. Refer to F314 for additional information.
F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that 7 of 7 CNA's (CNA's A, B, D, E, F, G and H) were able to demonstrate competency in providing incontinent care and infection control for 5 residents observed receiving incontinent care, as evidenced by: -When providing incontinent care for Resident # 37, CNA A did not wash hands and change gloves after performing perineal care for Resident # 37. -When providing incontinent care for Resident # 46, CNA H did not wash or sanitize her hands or change gloves after cleansing the resident's buttocks on two occasions. - When providing incontinent care for Resident # 89, CNA B lowered the head of the bed while the enteral feeding was continuing to run and turned the enteral feeding both off and on. -When providing incontinent care for Resident # 109, CNA's D and E did not wash hands and change gloves after performing pericare prior to repositioning Resident # 109 in her bed. -When providing incontinent care for Resident # 110, CNA's F and G left Resident # 110's soiled pants at the foot of the bed and placed Resident # 110's clean pants in contact with the soiled pants. These failures affected 5 residents and placed the other 93 incontinent residents at risk for cross contamination and the development of infection. The findings included: Resident # 37 An observation on 04/30/2015 at 09:25 AM revealed CNA A did not wash her hands or change her gloves after performing incontinent care on Resident # 37 just prior to assisting RN B reposition Resident # 37 up in bed. CNA A was also observed picking up a pillow off the floor after repositioning Resident # 37 up in bed without washing her hands or changing her gloves. In an interview with CNA A on 05/01/2015 at 09:45 AM, she stated that a CNA should remove their gloves and wash after performing incontinent care prior to repositioning a resident in bed or picking up a resident's pillow off the floor. Resident # 46 Record review of Resident # 46's facility medical record revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years old. An observation on 5/1/2015 at 10:40 am of CNA H performing peritoneal care on Resident # 46 revealed she did not wash or sanitize her hands or change gloves after cleansing the resident's buttocks on two occasions. CNA H was observed cleaning Resident # 46's buttocks. Without changing gloves or washing her hands, CNA H then began cleaning Resident # 46's vaginal area. After cleaning the vaginal area, CNA H washes her hands and changes gloves. CNA H then began cleaning the other side of Resident # 46's buttocks. She did not change gloves or wash her hands. With the same gloved hands, CNA H proceeded to fasten Resident 46's new brief, adjust her clothing and linen and adjust her nasal cannula tubing. In an interview on 5/1/2015 at 11:15 am with CNA H, she said she should have washed her hands and changed her gloves before cleansing Resident # 46's vaginal area and before donning the new brief, touching her clothing and adjusting her nasal cannula tubing. She further stated that she receives pericare and handwashing inservices all the time. However, she did not remember when the most recent training occurred. Resident # 89 Record review of Resident # 89's face sheet revealed a [AGE] year old female admitted to the facility on [DATE] with a readmission date of [DATE]. Among her [DIAGNOSES REDACTED]. An observation on 04/28/2015 at 04:26 PM, revealed that CNA's A and B when performing incontinent care placed the soiled sheet in a position in which it was touching the clean sheet just prior to placing the clean sheet in position under Resident # 89. In an observation of incontinent care on 04/28/2015 at 04:26 PM, CNA B was observed lowering the head of the bed while the enteral feeding was running and turning off and on Resident # 89's enteral nutrition feeding pump. In an interview with CNA A on 05/01/2015 at 09:45 AM, she stated that facility policy does not allow a CNA to either turn on or off a feeding tube. She further stated that in orientation she was instructed that a nurse is the only employee who is allowed to turn feeding tubes either on or off. CNA A stated that CNA B should have asked a nurse to turn off and then on Resident # 89's enteral feeding during the performance of incontinent care on 04/28/2015. Resident # 109 Record review of Resident # 109's face sheet revealed a [AGE] year old female admitted to the facility on [DATE]. Among her [DIAGNOSES REDACTED]. In an observation on 04/29/2015 at 09:20 AM, CNA's D and E did not wash their hands or change their gloves after performing incontinent care prior to repositioning Resident # 109 up in her bed. In an interview with CNA's D and E on 04/29/2015 at 10:30 AM, when questioned both stated they were nervous and that they should have washed their hands and changed their gloves after performing incontinent care prior to repositioning Resident # 109 up in bed. Resident # 110 Record review of Resident # 110's face sheet revealed a [AGE] year old female admitted to the facility on [DATE]. Among her [DIAGNOSES REDACTED]. In an observation on 04/28/2015 at 04:00 PM, CNA's F and G removed Resident # 110's soiled pants and placed them on the foot of the bed when performing incontinent care. Resident # 110's clean pants were placed on top of the soiled pants just prior to assisting Resident # 110 with her clean pants. In an interview on 04/30/2015 at 3:30 PM, CNA F stated that Resident # 110 soiled pants should have been placed in the soiled laundry bag at the time of removal. She stated she knows this and was not sure as to why she contaminated Resident # 110's clean pants at the time she was assisting Resident # 110 with her clean pants. In an interview on 05/01/2015 at 02:55 with ADON, she stated that staff members performing care are trained to wash their hands after contact with soiled briefs, bedding, or personal clothing prior to assisting residents with clean briefs, bedding or personal clothing. She further stated that soiled items should not be placed on top of clean items. Record review of the facility's revised December 2011 Perineal Care read in part .Wash the perineal area, wiping from front to back .4. Gently dry perineum. *Avoid step 3 and 4 when using pre-moisten disposable wipes. C. Instruct or assist the

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F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 15) resident to turn on her side .11. Discard disposable items into designated containers. 12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. 13. Put on clean gloves and place new brief and secure in place . Record review of the facility's policy and procedure revised December 2007 Standard Precautions, read in part, .Hand hygiene .d. Wash hands after removing gloves .Gloves .g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments . Record review of the facility's policy and procedure titled Handwashing/Hand Hygiene, revised April 2010, read in part This facility considers hand hygiene the primary means to prevent the spread of infections .1) All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .3) Hand hygiene products and supplies shall be readily accessible and convenient for staff use to encourage compliance .5) Employees must wash their hands for at least fifteen seconds using antimicrobial or non-microbial soap and water under the following conditions: a) When coming on duty; b) when hands are visibly soiled; c) before and after direct resident contact .d) before and after any invasive procedure .e) before and after entering isolation precaution settings .f) before and after handling food .g) before and after assisting a resident with food .h) before and after assisting a resident with personal care . According to the facility's CMS Form 672, the facility census was 114.