NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP THE VOSSWOOD NURSING CENTER 815 S VOSS RD HOUSTON, TX 77057 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG

OR LSC IDENTIFYING INFORMATION Protect each resident from all types of abuse such as physical, mental, sexual abuse,

Level of harm - Immediate

physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY >
Based on interview and record review, the facility failed to ensure residents were free from neglect for 1 of 14 residents (CR #1) reviewed for neglect.

Residents Affected - Few

The facility failed to have procedures in place for residents who are non-compliant with smoking in the facility. The facility failed to have procedures addressing residents with history of illicit drug use.

The facility failed to have procedures in place to ensure adequate monitoring of a resident after incident of suspected

The facility failed to have procedures in place to ensure adequate monitoring of a resident after incident of suspected illicit drug use in the facility.

The facility failed to ensure staff were trained on what to monitor on a resident with possible drug abuse.

The facility failed to have procedures in place that ensured CR#1's physician's orders [REDACTED].

CR #1 admitted to the facility with above issues. He was found with a used syringe and needle wrapped in a toilet tissue paper in his bathroom on one incident. CR#1was found dead with a syringe, needle and Heroin in his bathroom sink 4 days later.

An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility was continuing to train staff and monitor the effectiveness of the Plan of Removal.

These failures affected one closed record who died .

Findings include: TX 779/Intake #

CR #1

F 0600

jeopardy

Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED].

Record review of the facilities Pre-Admission Assessment for CR #1 dated [DATE] revealed he was admitted to local hospital

Record review of the facilities Pre-Admission Assessment for CR #1 dated [DATE] revealed he was admitted to local hospital on [DATE]. The assessment revealed the resident was homeless living in his car before admission to the hospital. His admitting [DIAGNOSES REDACTED]. Further review of the assessment revealed the resident was accepted into the facility. There were no additional notes on the assessment addressing the substance abuse or use of cigarettes.

Record review of CR #1's History and Physical (H&P) dated [DATE] completed by NP, revealed a social history stating, current every day smoker, drinks beer ,[DATE] times per week, no illicit drug abuse. CR#1's H&P revealed review of Miscellaneous labs stating, urine drug screen [DATE] positive with opiates. The H&P summary of Plans did not address the resident's positive drug screen, history of drug use, or current cigarette use.

Record review of CR #1's Admissions Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) composed of 15 indicates the president to the president of the MDS may and a CR #1 below to present the president of the MDS may are th

score of 15 indicating the resident was cognitively intact. Further review of the MDS revealed CR #1 had no current Tobacco

Record review of CR #1's hospital record dated [DATE] revealed a social history - He uses heroin and has a history of [MEDICATION NAME] use in the past. He smokes cigarettes. He denies alcohol use. Urine drug screen was positive for opiates. The Impression was At this time, I strongly suspect the fever is related to the fracture and also possible drug fevers. Record review of CR #1's record revealed no baseline care plan on admission on file.

Record review of CR #1's record revealed no care plan addressing the resident's history or risk of substance abuse and

Record review of CR #1's record revealed no care plan addressing the resident's instory of risk of substance abuse and smoking following admission.

Record review of CR #1's progress notes dated [DATE] at 11:14AM revealed, Doctor here to see resident with new orders for Intravenous Antibiotics (IVABT) and labs. Pharmacy notified of peripherally inserted central catheter (PICC) placement and orders faxed to pharmacy. Resident was informed of IVABT for [MEDICAL CONDITION] lower extremities. Note was written by

Record review of CR #1's progress notes dated [DATE] at 10:16AM revealed, Attempted to flush and hang IVABT via PICC at 7:00AM. Unable to flush. Assessed IV and noted rubber cap off PICC line site. Unit manager assessed also and noted. PICC line dislodged right upper arm. Call placed to pharmacy and request for PICC line reinsertion and will send nurse out. Resident informed IVABT will be given after insertion. Note was written by LVN#1. Record review of CR #1's progress notes dated [DATE] at 2:05PM revealed, RN here to reinsert PICC line at 12:00PM. Orders for STAT chest x-ray for placement prior to restarting IVABT. Doctor here and informed of PICC line out and residents place notified X-ray entered with number 0.11. Resident aware [MEDICATION NAME] with held did be bedding at

Physician also notified. X-ray ordered with number 011. Resident aware. [MEDICATION NAME] with-held d/t bleeding at insertion site. Note was written by LVN#1.

Record review of CR #1's progress notes dated [DATE] referred to a late entry from [DATE] 10PM-6AM. The note revealed on [DATE] around 2:30AM, LVN #2 smelled a cigarette odor. She followed the smell and went to CR #1's room where she observed [DATE] around 2:30AM, LVN #2 smelled a cigarette odor. She followed the smell and went to CR #1's room where she observed him sitting on his bed smoking a cigarette. She politely informed him that smoking was not permitted in residents' room. The resident responded by cursing and yelling at her saying, What the [***] you going to do. [***] you. Get out of my room. LVN #2 called the unit manager and she instructed her to get another nurse and get the cigarettes away from the resident. She returned to the room with a second nurse who also said he could smell smoke and informed CR #1 they had to quickly check his drawer for cigarettes and lighter to avoid accidents and danger. The other nurse reached for the drawer and CR #1 punched the nurse and began hitting him in the head with the phone. The resident continued to curse and hit the nurse with objects while they were asking the resident to stop and calm down. The nurse was able to discover a pack of cigarettes and some medication that were in the drawer. The staff left out of the room and the resident followed them to the nurse's station while continuing to yell and curse. LVN #2 called the Physician and the family. Note was written by LVN#2. Phone interview on [DATE] at 9:08AM, LVN #2 confirmed she was the nurse who observed CR #1 smoking in his bedroom on [DATE]

around 2:30AM during the 10PM - 6AM shift. She said she smelled smoke and walked down the hall to see where it was coming from and observed CR #1 sitting on the end of the bed with a cigarette butt in his mouth. She asked him what he was doing and told him he could not smoke in the facility and he began to yell and curse at her. She then called the unit manager and and told minimal count most smoke in the facting and the began to yet and curse at let. She take to the resident over the phone, but he would not stop yelling and cursing. The unit manager attempted to talk to the resident over the cigarettes and lighter. She got another male nurse (RN#2) and they attempted to remove the cigarettes and the resident began to fight the male nurse and hit him with the phone and other objects nearby. They recovered some cigarettes and [MEDICATION NAME] pills. She later wrote up what happened and was told by the DON they shouldn't go to the room again and another nurse should take over the room. another nurse should take over the room

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PRINTED:1/21/2019

NAME OF PROVIDER OF SUPPLIER THE VOSSWOOD NURSING CENTER		815 S VOSS RD HOUSTON, TX 7	7057
		STREET ADDRES	STREET ADDRESS, CITY, STATE, ZIP
	675080		
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING	10/08/2018
STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
CENTERS FOR MEDIC	ARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391

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

F 0600

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)
Record review of RN #1's written statement dated [DATE] revealed when she arrived for her shift (6am - 10pm) on [DATE] she Record review of RN #1's written statement dated [DATE] revealed when she arrived for her shift (6am - 10pm) on [DATE] she was immediately informed of a smoking incident that had taken place with CR #1 and had led to combative behavior. The night nurse (LVN#2) told her the resident was still there and per the 6AM -2PM nursing staff the resident did not present anymore behaviors at that time. Later during the 6AM -2PM shift it was brought to her attention that an unfamiliar needle, syringe device was retrieved from CR #1's bathroom floor. RN #1 confirmed in her statement it was not a needle used at the facility. The nurse assigned to the resident (LVN #3) also confirmed the syringe was not used by her or on her cart. She called the DON and left a voicemail. RN#1 instructed LVN #3 to call the physician and request for labs for a drug panel or to have the resident sent out to be evaluated or treated. She further noted LVN #3 denied the resident presented any violent behaviors or change in condition during her shift. RN #1 wrote she then texted the DON to inform her of the needle device fround in room due to be root answering the phone. During this time the on-call provider returned the phone call and violent behaviors or change in condition during her shift. RN #1 wrote she then texted the DON to inform her of the needle device found in room due to her not answering the phone. During this time the on-call provider returned the phone call, and she witnessed LVN #3 suggest a drug panel or for the resident to be sent out to the hospital. The on-call provider gave directives to monitor for change in condition and if so to discharge to the hospital. During that time the resident was noted to be stable with no behaviors. Shortly after staff spoke with the on-call provider the DON replied to the text and said she was out of town and asked if the device was removed, use caution entering his room, go in pairs, see what his intentions were, and to get family involved. The resident was closely monitored for the rest of the weekend and did not present any cause for concern. On Sunday morning [DATE] the Administrator was notified when he was noted in the building and he also said to monitor resident, report change, and send out if needed.

Record review of CR #1's progress notes dated [DATE] at 2:27PM, revealed the DON spoke with the resident regarding his behavior- smoking in his room. The Resident denied hitting anyone and said they found a pack of cigarettes that were not open, and some [MEDICATION NAME] pills he kept for his own use. The resident was educated about the facility being smoke-free and he was not allowed to smoke anywhere on the premises and failure to follow the policy could result in

open, and some [MEDICATION NAME] pills he kept for his own use. The resident was educated about the facility being smoke-free and he was not allowed to smoke anywhere on the premises and failure to follow the policy could result in discharge. Resident denied smoking in the room and said he had just come from smoking outside and that's why he smelled of smoke. He was also told he could not keep medications in room and if he felt he needed something the Physician would order it. The resident said he was preparing to discharge next week, and he wanted to be with his family in another town. The DON informed social services of his wishes. Residents care plan was updated to reflect non-compliant behavior in smoking, combativeness towards staff and taking medication not prescribed by the Physician.

Record review of CR #1's Care Plan dated [DATE] revealed resident is at risk for non-compliancy with smoking in the room, exhibiting needed of manipulation combativeness and verbal agreession towards staff as reported by pursing staff. The

exhibiting periods of manipulation combativeness and verbal aggression towards staff, as reported by nursing staff. The goal was, Resident will experience minimal adverse effects from non-compliance through next review, with a target date of [DATE]. The approaches were to, anticipate care needs and provide them before the resident becomes overly stressed, if reasonable, discuss behavior with resident. Explain/reinforce why behavior is unacceptable. Intervene as needed to protect the rights and safety of other. Investigate/observe need for psychological/psychiatric support. Provide services if desired by resident/responsible party as ordered by the physician. Report to physician changes behavioral status. Attempt to provide a safe living environment for resident daily. Discuss compliancy and potential results of non-compliancy with

patient.
Further review of above care plan revealed it did not address CR#1's drug use history and it did not address nursing staff's concern regarding CR#1's PICC line.

concern regarding CR#1's PICC line.

Record review of CR #1's progress notes dated [DATE] at 10:18PM revealed in part, Resident appetite has decreased, and he has not been eating his meals. Resident was observed by a Physical Therapy assistant sitting on the toilet for an extended period of time with a syringe and needle on the floor next to him. Resident was asked where the syringe came from by charge nurse and resident stated he did not know what the charge nurse was talking about. Resident appeared to have slight change in mental status, he was slurring his speech and stated that he was feeling dizzy. Resident vitals were obtained ,[DATE], 88, 20, 97.5, 98%. Resident breathing was even and unlabored with no complaints of shortness of breath. Resident received Physical therapy services. Resident left off premises at 7:32PM, stated he was going out with his family member to get something to eat, as of 10:30PM resident still has not returned. Informed 10PM-6AM shift nurse that resident had not returned. Resident did not receive any 8:00PM medications. Will continue to monitor. Progress note was signed by LVN #3. Further review of CR#1's record revealed there was no further follow up on this incident by the facility administrator and DON.

Interview on [DATE] at 1:00PM, LVN #3 confirmed she completed the note about the syringe being found in CR #1's room on IDATE] At 15 at 1,00 M, 10 M, 20 M, 20 M, 20 Completed the role about the sylingle being found in CR #1 stofin on IDATE]. She said she was on break around noon and when she returned another nurse told her about the needle being found in the restroom with the resident and she had placed it in the med room for her to examine. She examined the needle and confirmed it was not a needle that was used in the facility and said it appeared to be old due to the numbers being worn off. LVN #3 began to get emotional as she explained how she had a close relationship with the resident and was unaware of his history of drug use. She said after she examined the needle she went to CR #1's room and observed him coming out of the restroom and he complained of being dizzy and was slurring his speech. She assisted him to the bed and asked him what was roing on Ha danied having the surring and each he falt. going on. He denied having the syringe and said he didn't know what she was talking about. She took his vitals and she felt they were normal for him. She went to the nurse's station and the weekend unit manager (RN #1) was there and already knew of the incident. She said they then called the on-call NP and was instructed not to do any labs and to monitor the resident for changes and if there are changes to send to the hospital. LVN #3 reported she worked 6AM - 10PM on Saturday and Sunday and did not observe any changes or concerns in the resident during that time. She revealed she was very concerned about him after the incident, so she closely monitored him and kept track of where he was.

Record review of CR #1's written physician's orders [REDACTED]. [DIAGNOSES REDACTED].

Record review of CR #1's transcribed physician's orders [REDACTED].

Record review of CR #1's progress notes dated [DATE] at 10:43PM revealed in part, Resident receiving IVABT [MEDICATION NAME].

for osteo[DIAGNOSES REDACTED], heel wound and amputated great toe. No adverse reactions noted (NARN). Afebrile. PICC

to upper right arm, dressing dirty with blood, will need to be changed. PICC line is patent, with [MEDICATION NAME] lock. Resident complained of abdominal pain and diarrhea, gave Questran to aid with loose stools. Resident is continent of bowel and bladder and a one person assist when needed. Resident receiving PT/OT skilled services, resident is able to ambulate with aid of walker.

with aid of waiter.

Record review of CR #1's progress notes dated [DATE] at 3:55pm revealed the resident was visited for an admission evaluation by another facility representative. Note further revealed per evaluation the resident was clinically accepted for admission, insurance authorization was pending.

Record review of the facility's incident report dated [DATE] revealed CR #1 was found unresponsive on his bathroom floor

around 6:30AM on [DATE]. Code Blue was initiated and 911 was called. Cardiopulmonary resuscitation (CPR) was started. Emergency Medical Services (EMS) arrived and took over and pronounced the resident at 7:07AM. The EMS note syringe with clear substance next to sink and black plastic spoon with small brown colored rock like substance in front of sink. Houston Police Department (HPD) was notified and on scene at 7:35AM as well as Medical Examiner as of 9:19AM. Incident was observed.

Police Department (HPD) was notified and on scene at 7:35AM as well as Nectical Examined as 67.77AM. Included and shift 6am - 2pm.

Record review of LVN #4's written statement dated [DATE] revealed she came to the 2nd floor on [DATE] around 2:00AM to make rounds on CR #1 in room [ROOM NUMBER] and LVN #2 stated she saw him go down in the elevator to go outside and smoke. She went back to the 5th floor where she was assigned. She returned to the 2nd floor to administer any 6:00AM meds for CR #1 but noted the Medication Administration Record [REDACTED]. The night nurse and morning nurse were notified the patient did not have 6:00AM meds and went back to her 5th floor station.

Interview on [DATE] at 5:47AM, LVN #1 confirmed she was the nurse to discover CR #1 unresponsive in his restroom on [DATE] around 6:30AM. LVN #1 said she had just come onto her shift and was headed to CR #1's room when CNA #1 came out of the room and told her the resident was on the floor. She went into the room and found the resident unresponsive on the bathroom

around 6:30AM. LVN #1 said she had just come onto her shift and was headed to CR #1's room when CNA #1 came out o and told her the resident was on the floor. She went into the room and found the resident unresponsive on the bathroom floor lying in fetal position. She called out to the resident and he did not respond, she checked his pulse and called a code blue. Resident was pulled out into room area, CPR was started and 911 was called. LVN #1 said the resident body presented signs as if he had been lying there for a while, she did not elaborate. She further said she raised up the resident's shirt in attempts to find his cell phone to notify family and found a syringe. She said there was also a black plastic spoon and some brown rock like substance that she suspected to be heroin. There was also a paper towel with a nickel size blood spot on it and the hot water was running in the sink when she entered the room. She felt something was wrong when she saw the light on in the resident's room because the resident was not usually awake at that time, he usually

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CENTERS FOR MEDICARE & MEDICAID SERVICES X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING ____ 10/08/2018 675080 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP THE VOSSWOOD NURSING CENTER 815 S VOSS RD HOUSTON, TX 77057 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 2) slept in until around 11:00AM. LVN #1 said she had no idea the resident had a history of [REDACTED]. The nurse from the F 0600 slept in until around 11:00AM. LVN #1 said she had no idea the resident had a history of [REDACTED]. The nurse from the night shift did not give her a report of any concerns or incidents for CR #1. She added the resident was a smoker and would often leave out of the facility to go and smoke.

Interview on [DATE] at 5:59AM, CNA #2 said she worked 10PM - 6AM shift on the 2nd floor the night before CR #1 was found ([DATE]). CNA #2 said she made rounds around 10:00PM and the resident was not in his room and she assumed he was out smoking because he often left out the facility to go and smoke. The next time she saw the resident he was coming out the elevator between the time of 1:30AM - 2:30AM. CR #1 did not greet them at the nurses' station as he sometimes did and went into his room and closed the door. She did not see the resident for the rest of the night. She did not go into the resident's promable to the night because he does not like to be bothered when his door was closed. She said she could not speak on the resident's promable to him being a quiet pressor. CNA #2 was unaware of resident baying any current. Level of harm - Immediate jeopardy Residents Affected - Few resident's room the rest of the night because he does not like to be bothered when his door was closed. She said she could not speak on the resident's personality due to him being a quiet person. CNA #2 was unaware of resident having any current or past issues with drugs. CNA #2 added the resident would often leave out of the facility throughout the night to go smoke. Interview on [DATE] at 7:30AM, the social worker said CR #1 did not self-disclose a history of drug use to her during her assessment. The social worker said the resident did not present behaviors for her to suspect current issues with substance abuse, therefore it was not addressed. She had spoken with the resident on [DATE] concerning his request to discharge to a non-smoke free facility. The social worker found a smoking facility to accept the resident and the Interdisciplinary Team (IDT) and Nursing Services were aware. The incident on [DATE] with CR #1 being found with a syringe and needle was not brought to her attention until their morning meeting after he had passed on [DATE]. Due to her being unaware of the incident she did not reassess the resident for drug abuse or make any referrals.

Phone interview on [DATE] at 9:15AM, LVN #2 said she came to work Monday night ([DATE]) and did not go into CR #1's room as the DON instructed her to do but did make observations of him in his room while walking the halls. She observed CR #1 in his room around 10:05PM sitting on his bed due to his door being open. She observed CR #1 leaving out of the elevator between 2:00AM - 2:30AM. She did med pass around 4:00AM and saw CR #1 lying in his bed due to the door being open. LVN #2 said she then called the nurse assigned to him (LVN #4) to give him his meds and LVN #4 said she would be down in a minute. LVN #2 added she was not aware of resident having history of substance abuse, the incident of resident being found with a syringe on [DATE], or the orders for the resident to be monitored for suspicions of drug use. LVN #2 added the resident would often leave would often leave out of the facility throughout the night without signing out, it was always assumed he was smoking Outside.

Interview on [DATE] at 9:50AM, the Unit Manager said LVN #2 had called her around 3:00AM and told her about CR #1 smoking in his room and his behavior when she confronted him. She had LVN #2 put her on speaker and attempted to talk to CR #1, but the resident was yelling and screaming refusing to listen. She told LVN #2 to leave the room and get another nurse to remove the cigarettes and lighter. She texted the DON and Administrator to determine if the police should be called. Before remove the cigarettes and ingiter. She texted the DON and Administrator to determine it the police should be called. Before they could respond she heard back from the nurses they were able to retrieve the cigarettes and medications and was told about his fighting the staff. She came in shortly after 3:00AM to see the resident and address the situation but the resident had already fallen asleep. The DON spoke with the resident when he woke up later in the day. The Unit Manager added she was shocked by his behavior and she had never saw the resident act in that way. She also confirmed CR #1 would often go outside to smoke or leave the premises with a woman. She said CR #1 was non-compliant with signing out and she would often get onto him about signing out.

Interview on [DATE] at 10:20AM, the Unit Manager said she was aware CR #1 had a history of [REDACTED]. She said the resident had a few issues with his PICC line and she wondered if he was messing with it but did not want to assume or accuse without evidence. She questioned the resident on one occasion where she found the PICC line bloody as if it had been tampered with and CR #1 claimed the nurse who came in earlier had flushed the line and caused the mess. The Unit Manager said she was not and CR #1 claimed the nurse who came in earlier had flushed the line and caused the mess. The Unit Manager said she was not aware of the incident that happened over the weekend ([DATE]) with the resident being found with a syringe and needle until after he was found deceased on [DATE].

Interview on [DATE] at 12:45PM, CNA #3 said around 12:00PM on [DATE] she was in a room assisting with feeding when a nurse asked her to step out to the hall. The nurse asked where CR #1 was when she went to pass his lunch tray. They both went into CR #1's room and opened the bathroom door and observed him on the toilet with a syringe on the floor wrapped in toilet paper with blood on it. CR #1 told them to get out because he had diarrhea. The nurse (LVN#5) was able to grab the syringe from off the floor before they left the room. She added that when she went to pass the lunch tray earlier the resident was not in the room and she assumed he had gone downstairs to smoke.

Interview on [DATE] at 5:00PM, there was no response and the property of the property o Attempts were made to contact LVN #4 via phone on [DATE] at 1:20PM and [DATE] at 5:00PM, there was no response and voicemail was left with no return phone calls.

Attempt was made to contact LVN #5 via phone on [DATE] at 1:25PM, there was no response and voicemail was left with no Attempt was made to consider LVN#3 via prione on [DATE] at 1.25FM, there was no response and voicentant was left with no return phone calls.

Record review of CR #1's clinical record revealed no documentation of labs, assessments, or referrals addressing substance abuse or resident's ability to smoke outside the facility since his admission. There was also no check out log to indicate when the resident had left and returned to the facility or evidence the resident had been counseled about it.

Interview on [DATE] at 4:00PM, the Administrator and DON said the company had Liaisons who go into hospitals to assess resident and clear them to be admitted to the facility. The Administrator and DON when asked said CR#1 was admitted to the facility documents the resident was overaged to the resident was not response and voicental was not returned to substance abuse. facility despite his history of substance abuse due to no indication the resident was currently using drugs. The Administrator and DON when asked said CR#1 had no care plan for risks of substance abuse upon his admission because facility did not feel the resident presented concerns. There were also no smoking assessments completed or care plan addressing smoking for the resident because the facility was non-smoking. The Administrator said staff were aware of the resident leaving the facility to smoke and him leaving the facility for extended periods of time. The DON said she attempted to counsel with the resident on checking out of the facility, but he continued to be non-compliant. The Administrator and the DON said after the incident on [DATE] when CR #1 was found with a syringe and needle, they responded accordingly by notifying the Physician and following the orders to monitor the resident. They confirmed CR #1's care plan accordingly by notifying the Physician and following the orders to monitor the resident. They confirmed CR #1's care plan was not updated to reflect the incident, there were no assessments or referrals made, and there were no additional interventions put in place for the resident. The DON said there were no in-services completed for staff concerning signs of substance abuse or how to monitor for substance abuse issues. The DON said the resident was being monitored and there were no further concerns, signs, or changes after the incident that prompted them to do anything else. The DON gave no specifics on how the staff were monitoring the resident and she said the Physician did not specify that in her order. The DON said she knew the resident's vitals were taken every day and there was a nurse (LVN #3) on the weekend shift who closely monitored the resident by keeping track of where he was going and his status when he returned. The DON agreed there was a break in communication from the weekend staff and the week day staff. The weekday staff were not aware of CR#1's incidents and possible drug use which required staff to monitor him. The DON said the shift change report should have told the in-coming staff what was going on. The DON and Administrator reported even though staff were unaware of the incident with the syringe and the residents drug history, the resident was properly monitored and presented no changes to cause them to the syringe and the residents drug history, the resident was properly monitored and presented no changes to cause them to initiate any other interventions.

Interview on [DATE] at 3:00PM, CR #1's Physician said she came into the facility on [DATE] and discontinued an order for [REDACTED]. She did not address the situation that happened on [DATE] with the syringe during her visit because she was unaware of the incident. She was not told about the incident until the morning meeting on [DATE] after the resident had passed. She confirmed she had now talked to her on-call NP who was contacted about the incident on [DATE] and she confirmed she gave orders to monitor the resident for changes and send out if there were changes. She added she was also not aware of the resident combative behavior with staff when he was found to be smoking in his room on [DATE], she was only told the resident was smoking cigarettes and [MEDICATION NAME] were retrieved from his room.

Record review of Houston Police Department Report dated [DATE] at 7:11AM revealed an offense titled Death - Poison/Drugs. CR #1 was identified as the complainant in the report. The Brief Summary revealed. The complainant was found deceased in the syringe and the residents drug history, the resident was properly monitored and presented no changes to cause them to *H was identified as the complainant in the report. The Brief Summary revealed, The complainant was found deceased in nursing home by the attending nurse. A syringe with needle and a small amount of heroin was also found near the body. The report further revealed Houston Fire Department was on the scene and announced time of the death at 7:07AM, the complainant appeared to have been deceased for at least 2 hours because he was stiff and rigor mortis had started to set in. The reportee was listed as LVN #1, her statement revealed she found the resident deceased in bathroom around 6:30AM. She

alerted other staff to come help her, so they could initiate CPR and 911 was called. She stated she found a syringe with needle and a small amount of heroin on the sink of the bathroom and she suspected the complainant was shooting heroin prior

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X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING ____ 10/08/2018 675080 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP THE VOSSWOOD NURSING CENTER 815 S VOSS RD HOUSTON, TX 77057 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0600 to his death. Record review of the facility's Non-Smoking Facility policy (Last Revised [DATE]) revealed in part, smoking is not allowed, at any time, inside or outside the building or on the property by resident, staff, or visitors.

Record review of the facility's Protection of Residents: Reducing the threat of Abuse & Neglect policy (Last revised: Level of harm - Immediate jeopardy ,[DATE]) revealed in part, It is the policy and practice of this facility that all residents will be protected from all types of abuse, neglect, misappropriation of residents property, and exploitation. Further review revealed in part, The facility must: 2. Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of residents property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned Residents Affected - Few have knowledge of the individual resident care needs and behavioral symptoms, if any. 3. Assure that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited to, the provision of a facility assessment to determine what resources are necessary to care for its resident competently. The Administrator and the DON were notified of the Immediate Jeopardy on [DATE] at 4:15PM due to the above failures. A Plan The Administrator and the DON were notified of the Immediate Jeopardy on [DATE] at 4:15PM due to the above fa of removal was requested.

After revisions, the Plan of Removal was accepted on [DATE] at 12:00PM.

Immediate Jeopardy Plan of Removal

Completed [DATE]

1. Medical Director notified, and QA set for 3pm on [DATE]

2. Education began with Staff related to (completed by ED, DON, Unit Managers, RN Supervisor, Regional Nurse):
a. Sharps containers needing to be locked. Safe disposal of sharps.
b. Ensure areas free from hazardous materials
c. Immediate Notification of unusual occurrences or behaviors to MD, DON, ED
4. Clinical assessments and recognizing signs and symptoms of illegal drug uses d. Clinical assessments and recognizing signs and symptoms of illegal drug use
e. Residents Rights -v- Safety (check on but do not disturb unless necessary)
3. Residents educated on (Completed by Social services Director, Social Services Assistant):
a. Residents Rights -v Safety (will be checked on but not disturbed unless necessary) b. Facility is non-smoking (except for the grandfathered in people in facility as of ,[DATE]) c. Requirements to sign in and out when leaving the property 4. Audits completed:
a. Sharps containers locked (Audits by Nurses) a. Snarps containers locked (Adunts by Nurses)
b. Current residents (,[DATE]) checked for smoking history/activity and/or history of illegal substance abuse (audits by DON, SDC, Case Manager, MDS nurses, Unit Managers)
Any residents identified with a smoking history or substance abuse history the care plan was reviewed and revised as needed.
c. Room rounds completed by department heads and no potentially hazardous items were identified. Rounds will be completed ,[DATE] times weekly. Completed [DATE] 1. Continued Education of Staff as above Completed current resident education as per above
 Audited new admission charts for history of F 0689 Ensure that a nursing home area is free from accident hazards and provides adequate Ensure that a nursing nome area is tree from accident nazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY >

Based on interview, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 14 residents (CR #1) reviewed for accidents and supervision, in that;

CR#1 known to have history of substance abuse was not provided adequate supervision to prevent continued use of illicit Level of harm - Immediate jeopardy Residents Affected - Few drugs.

CR#1's baseline care plan and admission comprehensive assessment care plan did not address CR#1's history of illicit drug CR#1 was not adequately monitored and supervised after incidents of smoking in his room and possible illicit drug paraphernalia. CR#1 was found dead in his bathroom with syringe, needle and heroin on his bathroom sink. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility was continuing to train staff and monitor the effectiveness of the Plan of Removal. These failures affected one closed record who died . Findings include: CR #1 Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED].
Record review of the facilities Pre-Admission Assessment for CR #1 dated [DATE] revealed he was admitted to local hospital on [DATE]. The assessment revealed the resident was homeless living in his perfore admission to the hospital. His admitting [DIAGNOSES REDACTED]. Further review of the assessment revealed the resident was accepted into the facility. There were no additional notes on the assessment addressing the substance abuse or use of cigarettes. Record review of CR #1's History and Physical (H&P) dated [DATE] completed by NP, revealed a social history stating, current every day smoker, drinks beer ,[DATE] times per week, no illicit drug abuse. CR#1's H&P revealed review of Miscellaneous labs stating, urine drug screen [DATE] positive with opiates. The H&P summary of Plans did not address the resident's positive drug screen [batter] of the new or current circuits as the resident of the new or current circuits as the contraction of the new or current circuits as the contraction of the new or current circuits as the contraction of the new or current circuits as the contraction of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or current circuits as the contract of the new or cont positive drug screen, history of drug use, or current cigarette use.

Record review of CR #1's Admissions Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Further review of the MDS revealed CR #1 had no current Tobacco use.

Record review of CR #1's hospital record dated [DATE] revealed a social history - He uses heroin and has a history of [MEDICATION NAME] use in the past. He smokes cigarettes. He denies alcohol use. Urine drug screen was positive for opiates. The Impression was At this time, I strongly suspect the fever is related to the fracture and also possible drug fevers. Record review of CR #1's record revealed no baseline care plan on admission on file.

Record review of CR #1's record revealed no care plan addressing the resident's history or risk of substance abuse and smoking following admission.

Record review of CR #1's progress notes dated [DATE] at 11:14AM revealed, Doctor here to see resident with new orders for Intravenous Antibiotics (IVABT) and labs. Pharmacy notified of peripherally inserted central catheter (PICC) placement and orders faxed to pharmacy. Resident was informed of IVABT for [MEDICAL CONDITION] lower extremities. Note was written by

LVN#1.

Record review of CR #1's progress notes dated [DATE] at 10:16AM revealed, Attempted to flush and hang IVABT via PICC at 7:00AM. Unable to flush. Assessed IV and noted rubber cap off PICC line site. Unit manager assessed also and noted. PICC line dislodged right upper arm. Call placed to pharmacy and request for PICC line reinsertion and will send nurse out. Resident informed IVABT will be given after insertion. Note was written by LVN#1.

Record review of CR #1's progress notes dated [DATE] at 2:05PM revealed, RN here to reinsert PICC line at 12:00PM. Orders for STAT chest x-ray for placement prior to restarting IVABT. Doctor here and informed of PICC line out and residents Physician also notified. X-ray ordered with number 011. Resident aware. [MEDICATION NAME] with-held d/t bleeding at insertion site. Note was written by LVN#1.

Record review of CR #1's progress notes dated [DATE] referred to a late entry from [DATE] 10PM-6AM. The note revealed on [DATE] around 2:30AM, LVN #2 smelled a cigarette odor. She followed the smell and went to CR #1's room where she observed him sitting on his bed smoking a cigarette. She politely informed him that smoking was not permitted in residents' room.

Event ID: YL1011 Facility ID: 675080 FORM CMS-2567(02-99) If continuation sheet

DDINTED:1/21/2010

CENTERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/08/2018
NAME OF PROVIDER OF SUI THE VOSSWOOD NURSING	PPLIER	815 S VC	ADDRESS, CITY, STA OSS RD ON, TX 77057	TE, ZIP
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the s		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIENCY MU MATION)	JST BE PRECEDED BY	FULL REGULATORY
F 0689 Level of harm - Immediate jeopardy Residents Affected - Few	She returned to the room with a second nurse who also said he could smell smoke and informed CR #1 they had to quickly check his drawer for cigarettes and lighter to avoid accidents and danger. The other nurse reached for the drawer and CR #1			
	and told him he could not smoke stood in the doorway while telling phone, but he would not stop yell cigarettes and lighter. She got and began to fight the male nurse and IMEDICATION NAMEl pills. SI another nurse should take over the Record review of RN #1's written was immediately informed of a st nurse (LVN#2) told her the reside behaviors at that time. Later during device was retrieved from CR #1' facility. The nurse assigned to the called the DON and left a voicem to have the resident sent out to be violent behaviors or change in condevice found in room due to her rishe witnessed LVN #3 suggest a directives to monitor for change in noted to be stable with no behavisaid she was out of town and aske intentions were, and to get family present any cause for concern. Or and he also said to monitor reside Record review of CR #1's progres behavior-smoking in his room. Topen, and some [MEDICATION smoke-free and he was not allow discharge. Resident denied smokismoke. He was also told he could it. The resident said he was prepa informed social services of his wit combativeness towards staff and record review of CR #1's Care Plexhibiting periods of manipulatio goal was, Resident will experienc [DATE]. The approaches were to reasonable, discuss behavior with the rights and safety of other. Inw by resident/responsible party as o provide a safe living environment patient. Further review of above care plan concern regarding CR#1's PiCC 1 Record review of CR #1's progres has not been eating his meals. Reperiod of time with a syringe and nurse and resident stated he did ni mental status, he was slurring 188, 20, 97.5, 98%. Resident breat Physical therapy services. Reside something to eat, as of 10:30PM returned. Resident did not receive Further review of CR#1's record review of CR#1's transcribed and did not observe any changes after the incident, so she closely record review of CR#1's progres North and t	n the facility and he began to yell and curse, her what was going on. The unit manager in gand cursing. The unit manager instructe ther male nurse (RN#2) and they attempted hit him with the phone and other objects ne later wrote up what happened and was to e room. Statement dated [DATE] revealed when shooking incident that had taken place with Cnt was still there and per the 6AM -2PM mg the 6AM -2PM shift it was brought to he shathroom floor. RN #1 confirmed in her sresident (LVN #3) also confirmed the syrial. RN#1 instructed LVN #3 to call the phy evaluated or treated. She further noted LV didition during her shift. RN #1 wrote she thot answering the phone. During this time thrug panel or for the resident to be sent out in condition and if so to discharge to the hosts. Shortly after staff spoke with the on-cal diffused the vice was removed, use caution en involved. The resident was closely monito. Sunday morning [DATE] the Administrator, report change, and send out if needed. In the properties of the properties of the solution of the soluti	the at her. She then called a tempted to talk to the is altempted to talk to the is defered by the DON they should be arrived for her shift (6a CR #1 and had led to comursing staff the resident of the attention that an unfamiliar statement it was not a nee nege was not used by her ysician and request for late then texted the DON to in the on-call provider return to the hospital. The on-capital. During that time the Ill provider the DON replantering his room, go in pored for the rest of the we or was notified when he they found a pack of cig resident was educated ab failure to follow the polirom smoking outside and it he needed something the to be with his family in effect non-compliant behavior and the they found a pack of cig to be with the staff, as reported by inches the come is unacceptable. Intervent which is the compliant of the compliant of the polirom smoking outside and to be with his family in effect non-compliant behaviorian. It is not to do any labs and to a lin part, Resident appeared by the compliant of the resident become is unacceptable. Intervent with the staff, as reported by inches the subject of the resident become is unacceptable. Intervent with the staff of the resident become is unacceptable. Intervent with the staff of the resident about. Resident appeared by the facilit assistant sitting on the to examine. She examine do to be old due to the nu lationship with form and observed as stalking about. She took int manager (RN #1) was not to do any labs and to it is the worked 6AM - 10Pi. She revealed she was very the stalking about. She took int in manager (RN #1) was not to do any labs and to it is the worked 6AM - 10Pi. She revealed she was very the stalking about the syring being the facility of the facili	the unit manager and resident over the unres and remove the sand the resident me cigarettes and aldn't go to the room again and m - 10pm) on [DATE] she abative behavior. The night lid not present anymore iliar needle, syringe still used at the or on her cart. She also for a drug panel or presented any form her of the needle need the phone call, and all provider gave ne resident was ied to the text and airs, see what his ekend and did not was noted in the building resident regarding his arettes that were not out the facility being cy could result in that's why he smelled of he Physician would order another town. The DON avior in smoking, the smoking in the room, roursing staff. The w, with a target date of so overly stressed, if e as needed to protect e services if desired tus. Attempt to compliancy with ldress nursing staff's e has decreased, and he heilet for an extended age came from by charge to have slight change obtained, IDATE], eath. Resident received illy member to get resident had not was signed by LVN #3. y administrator and found in CR #1's room on the needle being found in dthe needle and mbers being worn nt and was unaware of did him coming out of the und asked him what was this vitals and she felt is there and already knew monitor the resident M on Saturday and Sunday erry concerned about him The staff of the monitor of the lower of the continent of bowel to a substance of an admission mically accepted on his bathroom floor tion (CPR) was started.

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING ____ 10/08/2018 675080 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP THE VOSSWOOD NURSING CENTER 815 S VOSS RD HOUSTON, TX 77057 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG OR LSC IDENTIFYING INFORMATION F 0689 (continued... from page 5) clear substance next to sink and black plastic spoon with small brown colored rock like substance in front of sink. Houston Police Department (HPD) was notified and on scene at 7:35AM as well as Medical Examiner as of 9:19AM. Incident was observed Level of harm - Immediate no day shift 6am - 2pm.

Record review of LVN #4's written statement dated [DATE] revealed she came to the 2nd floor on [DATE] around 2:00AM to make rounds on CR #1 in room [ROOM NUMBER] and LVN #2 stated she saw him go down in the elevator to go outside and smoke. She went back to the 5th floor where she was assigned. She returned to the 2nd floor to administer any 6:00AM meds for CR #1 but noted the Medication Administration Record [REDACTED]. The night nurse and morning nurse were notified the patient did jeopardy Residents Affected - Few but noted the Medication Administration Record [REDACTED]. The night nurse and morning nurse were notified the patient did not have 6:00AM meds and went back to her 5th floor station.

Interview on [DATE] at 5:47AM, LVN #1 confirmed she was the nurse to discover CR #1 unresponsive in his restroom on [DATE] around 6:30AM, LVN #1 said she had just come onto her shift and was headed to CR #1's room when CNA #1 came out of the room and told her the resident was on the floor. She went into the room and found the resident unresponsive on the bathroom floor lying in fetal position. She called out to the resident and he did not respond, she checked his pulse and called a code blue. Resident was pulled out into room area, CPR was started and 911 was called. LVN #1 said the resident body research clause as if he had been lying there for a while, she did not alshorate. resented signs as if he had been lying there for a while, she did not elaborate. LVN #1 said the resident body presented signs as if he had been lying there for a while, she did not elaborate. She further said she raised up the resident's shirt in attempts to find his cell phone to notify family and found a syringe. She said there was also a black plastic spoon and some brown rock like substance that she suspected to be heroin. There was also a paper towel with a nickel size blood spot on it and the hot water was running in the sink when she entered the room. She felt something was wrong when she saw the light on in the resident's room because the resident was not usually awake at that time, he usually slept in until around 11:00AM. LVN #1 said she had no idea the resident had a history of [REDACTED]. The nurse from the often leave out of the facility to go and smoke.

Interview on [DATE] at 5:59AM, CNA #2 said she worked 10PM - 6AM shift on the 2nd floor the night before CR #1 was found ([DATE]). CNA #2 said she made rounds around 10:00PM and the resident was not in his room and she assumed he was out smoking because he often left out the facility to go and smoke. The next time she saw the resident he was out smoking because the often left out the facility to go and smoke. The next time she saw the resident he was coming out the elevator between the time of 1:30AM - 2:30AM. CR #1 did not greet them at the nurses' station as he sometimes did and went elevator between the time of 150/AM - 2:50/AM. CR #1 did not greet them at the nurses station as he sometimes did and we into his room and closed the door. She did not see the resident for the rest of the night. She did not go into the resident's room the rest of the night because he does not like to be bothered when his door was closed. She said she could not speak on the resident's personality due to him being a quiet person. CNA #2 was unaware of resident having any current or past issues with drugs. CNA #2 added the resident would often leave out of the facility throughout the night to go smoke. or past issues with drugs. CNA #2 added the resident would often leave out of the facility throughout the night to go smoke. Interview on [DATE] at 7:30AM, the social worker said CR #1 did not self-disclose a history of drug use to her during her assessment. The social worker said the resident did not present behaviors for her to suspect current issues with substance abuse, therefore it was not addressed. She had spoken with the resident on [DATE] concerning his request to discharge to a non-smoke free facility. The social worker found a smoking facility to accept the resident and the Interdisciplinary Team (IDT) and Nursing Services were aware. The incident on [DATE] with CR #1 being found with a syringe and needle was not brought to her attention until their morning meeting after he had passed on [DATE]. Due to her being unaware of the incident she did not reassess the resident for drug abuse or make any referrals.

Phone interview on [DATE] at 9:15AM, LVN #2 said she came to work Monday night ([DATE]) and did not go into CR #1's room as the DON instructed her to do but did make observations of him in his room while walking the halls. She observed CR #1 in his room around 10:05PM sitting on his bed due to his door being open. She observed CR #1 leaving out of the elevator between 2:00AM - 2:30AM. She did med pass around 4:00AM and saw CR #1 lying in his bed due to the door being open. LVN #2 said she then called the nurse assigned to him (LVN #4) to give him his meds and LVN #4 said she would be down in a minute. LVN #2 added she was not aware of resident having history of substance abuse, the incident of resident being found with a syringe on [DATE], or the orders for the resident to be monitored for suspicions of drug use. LVN #2 added the resident would often leave out of the facility throughout the night without signing out, it was always assumed he was smoking outside.

Interview on [DATE] at 9:50AM, the Unit Manager said LVN #2 had called her around 3:00AM and told her about CR #1 smoking in his room and his behavior when she confronted him. She had LVN #2 put her on speaker and attempted to talk to CR #1, but the resident was yelling and screaming refusing to listen. She told LVN #2 to leave the room and get another nurse to remove the cigarettes and lighter. She texted the DON and Administrator to determine if the police should be called. Before they could respond she heard back from the nurses they were able to retrieve the cigarettes and medications and was told about his fighting the staff. She came in shortly after 3:00AM to see the resident and address the situation but the resident had already fallen asleep. The DON spoke with the resident when he woke up later in the day. The Unit Manager added she was shocked by his behavior and she had never saw the resident act in that way. She also confirmed CR #1 would often go outside to smoke or leave the premises with a woman. She said CR #1 was non-compliant with signing out and she would often get onto him about signing out.

Interview on [DATE] at 10:20AM, the Unit Manager said she was aware CR #1 had a history of [REDACTED]. She said the resident had a few issues with his PICC line and she wondered if he was messing with it but did not want to assume or accuse without evidence. She questioned the resident on one occasion where she found the PICC line bloody as if it had been tampered with and CR #1 claimed the nurse who came in earlier had flushed the line and caused the mess. The Unit Manager said she was not surgested the incident that he present out that have located the line and caused the mess. The Unit Manager said she was not surgested the incident that he present out that have located (IDATE) with the surgested the line and days with a surgest each available that the present of the surgested that the present of the problem of the p and CR #1 claimed the nurse who came in earner had nushed the line and caused the mess. The Unit Manager said she was not aware of the incident that happened over the weekend ([DATE]) with the resident being found with a syringe and needle until after he was found deceased on [DATE].

Interview on [DATE] at 12:45PM, CNA #3 said around 12:00PM on [DATE] she was in a room assisting with feeding when a nurse asked her to step out to the hall. The nurse asked where CR #1 was when she went to pass his lunch tray. They both went into CR #1's room and opened the bathroom door and observed him on the toilet with a syringe on the floor wrapped in toilet paper with blood on it. CR #1 told them to get out because he had diarrhea. The nurse (LVN#5) was able to grab the syringe from off the floor before they left the group. She added that when she went to pass the lunch tray earlier the resident was from off the floor before they left the room. She added that when she went to pass the lunch tray earlier the resident was not in the room and she assumed he had gone downstairs to smoke.

Attempts were made to contact LVN #4 via phone on [DATE] at 1:20PM and [DATE] at 5:00PM, there was no response and was left with no return phone calls. Attempt was made to contact LVN #5 via phone on [DATE] at 1:25PM, there was no response and voicemail was left with no return phone calls. Record review of CR #1's clinical record revealed no documentation of labs, assessments, or referrals addressing substance abuse or resident's ability to smoke outside the facility since his admission. There was also no check out log to indicate when the resident had left and returned to the facility or evidence the resident had been counseled about it. Interview on [DATE] at 4:00PM, the Administrator and DON said the company had Liaisons who go into hospitals to assess resident and clear them to be admitted to the facility. The Administrator and DON when asked said CR#1 was admitted to the facility despite his history of substance abuse due to no indication the resident was currently using drugs. The Administrator and DON when asked said CR#1 had no care plan for risks of substance abuse upon his admission because facility did not feel the resident presented concerns. There were also no smoking assessments completed or care plan addressing smoking for the resident because the facility was non-smoking. The Administrator said staff were aware of the addressing smooth for the resident because the facility was ion-smoothing. The Administrators and start were aware of the resident leaving the facility to smoke and him leaving the facility for extended periods of time. The DON said she attempted to counsel with the resident on checking out of the facility, but he continued to be non-compliant. The Administrator and the DON said after the incident on [DATE] when CR #1 was found with a syringe and needle, they responded accordingly by notifying the Physician and following the orders to monitor the resident. They confirmed CR #1's care plan accordingly by notifying the Physician and following the orders to monitor the resident. They confirmed CR #1's care plan was not updated to reflect the incident, there were no assessments or referrals made, and there were no additional interventions put in place for the resident. The DON said there were no in-services completed for staff concerning signs of substance abuse or how to monitor for substance abuse issues. The DON said the resident was being monitored and there were no further concerns, signs, or changes after the incident that prompted them to do anything else. The DON gave no specifics on how the staff were monitoring the resident and she said the Physician did not specify that in her order. The DON said she knew the resident's vitals were taken every day and there was a nurse (LVN #3) on the weekend shift who closely monitored the resident by keeping track of where he was going and his status when he returned. The DON agreed there was a break in communication from the weekend staff and the week day staff. The weekday staff were not aware of CR#1's incidents and possible drug use which required staff to monitor him. The DON said the shift change report should have told the

FORM CMS-2567(02-99) Event ID Previous Versions Obsolete

1. Medical Director notified, and QA set for spin of [DA1E]
2. Education began with Staff related to (completed by ED, DON, Unit Managers, RN Supervisor, Regional Nurse):
a. Sharps containers needing to be locked. Safe disposal of sharps.
b. Ensure areas free from hazardous materials
c. Immediate Notification of unusual occurrences or behaviors to MD, DON, ED-

c. Immediate Notification of unusual occurrences or behaviors to MID, DON, ED-d. Clinical assessments and recognizing signs and symptoms of illegal drug use e. Residents Rights -v- Safety (check on but do not disturb unless necessary)

3. Residents educated on (Completed by Social services Director, Social Services Assistant):
a. Residents Rights -v Safety (will be checked on but not disturbed unless necessary)
b. Facility is non-smoking (except for the grandfathered in people in facility as of ,[DATE])
c. Requirements to sign in and out when leaving the property
4. Audits completed:
a. Sharps containers locked (Audits by Nurses)

DON, SDC, Case Manager, MDS nurses, Unit Managers)

Any residents identified with a smoking history or substance abuse history the care plan was reviewed and revised as needed.

C. Room rounds completed by department heads and no potentially hazardous items were identified. Rounds will be completed

,[DATE] times weekly. Completed [DATE]

Continued Education of Staff as above
 Completed current resident education as per above
 Audited new admission charts for history of smoking or substance abuse
 Audited Sharps containers

Audited Sharps containers
 Staff will not be allowed to return to work until education has been completed

Facility liaisons conduct bed side screenings and follow the facility capability grid to determine the appropriateness of the patient for the facility and the facilities ability to meet their needs.

2. At the time of the bed side screening the information is forwarded to the facility to the unit staff and information is placed on the 24 hour report and in shift to shift communication/report. If the referral has known

use of or history of drug use, alcohol use, smoking or a positive toxicology for these, then the referral will be sent to DON and ED for further evaluation to determine if facility can meet the needs of the patient.

3. Resident specific needs will be communicated to appropriate clinical staff at the time of admission and through shift to shift reporting.

4. The base line care plan is initiated at the time of admission and completed within 48 hours by the nursing staff and IDT. The base line care

F 0740

Ensure each resident must receive and the facility must provide necessary behavioral health care and services *NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** >

Level of harm - Immediate

Residents Affected - Few

Based on interview and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being, to include the prevention and treatment of [REDACTED].#1) reviewed for behavioral healthcare, in that; The facility failed to identify CR #1 had a history of [REDACTED].

The facility raised to identify CR #1 had a history of [REDACTED]. CR #1 was not provided mental health and substance abuse treatment after he presented behaviors of using drugs in the facility. CR #1 was found dead in his bathroom with a syringe and needle next to him and heroin on the bathroom sink. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility was continuing to train staff and monitor the effectiveness of the Plan of Removal.

These failures affected one closed record who died. Findings include:

Findings include: TX 779/Intake #

CR #1

Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED].

REDACTED].

Record review of the facilities Pre-Admission Assessment for CR #1 dated [DATE] revealed he was admitted to local hospital on [DATE]. The assessment revealed the resident was homeless living in his car before admission to the hospital. His admitting [DIAGNOSES REDACTED]. Further review of the assessment revealed the resident was accepted into the facility. There were no additional notes on the assessment addressing the substance abuse or use of cigarettes. Record review of CR #1's History and Physical (H&P) dated [DATE] completed by NP, revealed a social history stating, current every day smoker, drinks beer ,[DATE] times per week, no illicit drug abuse. CR#1's H&P revealed review of Miscellaneous labs stating, urine drug screen [DATE] positive with opiates. The H&P summary of Plans did not address the resident's positive drug screen, history of drug use, or current cigarette use.

Facility ID: 675080

FORM CMS-2567(02-99)

Event ID: YL1011

If continuation sheet

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING	10/08/2018	
CORRECTION	NUMBER			
NAME OF PROVIDER OF SUI	675080 PPLIER	STREET ADDRESS, CITY, STA	L ATE, ZIP	
THE VOSSWOOD NURSING	815 S VOSS RD HOUSTON, TX 77057	,		
For information on the nursing l	or 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 0740	(continued from page 7) Record review of CR #1's Admissi	ions Minimum Data Set ((MDS) dated [DATF] revealed a Brief Int	erview of Mental Status (RIMS	
Level of harm - Immediate jeopardy	Record review of CR #1's Admissions Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS score of 15 indicating the resident was cognitively intact. Further review of the MDS revealed CR #1 had no current Tobacco use. Record review of CR #1's hospital record dated [DATE] revealed a social history - He uses heroin and has a history of			
Residents Affected - Few	[MEDICATION NAME] use in the Impression was At this time, Record review of CR #1's record r	he past. He smokes cigarettes. He denies alcohol use. Urine drug sc I strongly suspect the fever is related to the fracture and also possib evealed no baseline care plan on admission on file.	reen was positive for opiates. le drug fevers.	
	smoking following admission.	evealed no care plan addressing the resident's history or risk of sub-		
	Record review of CR #1's progress notes dated [DATE] at 11:14AM revealed, Doctor here to see resident with new orders for Intravenous Antibiotics (IVABT) and labs. Pharmacy notified of peripherally inserted central catheter (PICC) placement and orders faxed to pharmacy. Resident was informed of IVABT for [MEDICAL CONDITION] lower extremities. Note was written by LVN#1.			
	Record review of CR #1's progress notes dated [DATE] at 10:16AM revealed, Attempted to flush and hang IVABT via PICC at 7:00AM. Unable to flush. Assessed IV and noted rubber cap off PICC line site. Unit manager assessed also and noted. PICC line dislodged right upper arm. Call placed to pharmacy and request for PICC line reinsertion and will send nurse out. Resident informed IVABT will be given after insertion. Note was written by LVN#1. Record review of CR #1's progress notes dated [DATE] at 2:05PM revealed, RN here to reinsert PICC line at 12:00PM. Orders			
	for STAT chest x-ray for placeme Physician also notified. X-ray ord insertion site. Note was written by	ent prior to restarting IVABT. Doctor here and informed of PICC linered with number 011. Resident aware. [MEDICATION NAME] was a support of the prior of the prio	ne out and residents vith-held d/t bleeding at	
	[DATE] around 2:30AM, LVN #2 him sitting on his bed smoking a c The resident responded by cursing	2 smelled a cigarette odor. She followed the smell and went to CR # cigarette. She politely informed him that smoking was not permitted and yelling at her saying, What the [***] you going to do. [***] y	#1's room where she observed d in residents' room. rou. Get out of my room.	
	She returned to the room with a so check his drawer for cigarettes an punched the nurse and began hitti	ind she instructed her to get another nurse and get the cigarettes awa econd nurse who also said he could smell smoke and informed CR # d lighter to avoid accidents and danger. The other nurse reached for ng him in the head with the phone. The resident continued to curse	#1 they had to quickly r the drawer and CR #1 and hit the nurse with	
	some medication that were in the station while continuing to yell an	e resident to stop and calm down. The nurse was able to discover a drawer. The staff left out of the room and the resident followed thei d curse. LVN #2 called the Physician and the family. Note was wi 18AM, LVN #2 confirmed she was the nurse who observed CR #1 s	m to the nurse's atten by LVN#2.	
	[DATE] around 2:30AM during the 10PM	- 6AM shift. She said she smelled smoke and walked down the hal on the end of the bed with a cigarette butt in his mouth. She asked h	l to see where it was coming	
	and told him he could not smoke in the facility and he began to yell and curse at her. She then called the unit manager and stood in the doorway while telling her what was going on. The unit manager attempted to talk to the resident over the phone, but he would not stop yelling and cursing. The unit manager instructed her to go get another nurse and remove the cigarettes and lighter. She got another male nurse (RN#2) and they attempted to remove the cigarettes and the resident began to fight the male nurse and hit him with the phone and other objects nearby. They recovered some cigarettes and			
	another nurse should take over the Record review of RN #1's written was immediately informed of a sm	statement dated [DATE] revealed when she arrived for her shift (6a noking incident that had taken place with CR #1 and had led to com	nm - 10pm) on [DATE] she abative behavior. The night	
	nurse (LVN#2) told her the resident was still there and per the 6AM -2PM nursing staff the resident did not present anymore behaviors at that time. Later during the 6AM -2PM shift it was brought to her attention that an unfamiliar needle, syringe device was retrieved from CR #1's bathroom floor. RN #1 confirmed in her statement it was not a needle used at the facility. The nurse assigned to the resident (LVN #3) also confirmed the syringe was not used by her or on her cart. She			
	called the DON and left a voicem to have the resident sent out to be violent behaviors or change in cor	ail. RN#1 instructed LVN #3 to call the physician and request for la evaluated or treated. She further noted LVN #3 denied the resident addition during her shift. RN #1 wrote she then texted the DON to in	abs for a drug panel or presented any form her of the needle	
	she witnessed LVN #3 suggest a directives to monitor for change in	tot answering the phone. During this time the on-call provider return drug panel or for the resident to be sent out to the hospital. The on-cn n condition and if so to discharge to the hospital. During that time the ors. Shortly after staff spoke with the on-call provider the DON repl	call provider gave he resident was	
	said she was out of town and aske intentions were, and to get family	d if the device was removed, use caution entering his room, go in p involved. The resident was closely monitored for the rest of the we	pairs, see what his sekend and did not	
	and he also said to monitor reside	1 Sunday morning [DATE] the Administrator was notified when he nt, report change, and send out if needed. s notes dated [DATE] at 2:27PM, revealed the DON spoke with the	_	
	behavior- smoking in his room. Topen, and some [MEDICATION] smoke-free and he was not allowed	he Resident denied hitting anyone and said they found a pack of cig NAME] pills he kept for his own use. The resident was educated ab dot o smoke anywhere on the premises and failure to follow the poli	garettes that were not bout the facility being acy could result in	
	smoke. He was also told he could it. The resident said he was prepar	ng in the room and said he had just come from smoking outside and not keep medications in room and if he felt he needed something the ring to discharge next week, and he wanted to be with his family in shes. Residents care plan was updated to reflect non-compliant beh.	ne Physician would order another town. The DON	
	combativeness towards staff and t Record review of CR #1's Care Pla exhibiting periods of manipulation	aking medication not prescribed by the Physician. an dated [DATE] revealed resident is at risk for non-compliancy win combativeness and verbal aggression towards staff, as reported by	th smoking in the room, y nursing staff. The	
	[DATE]. The approaches were to reasonable, discuss behavior with	e minimal adverse effects from non-compliance through next revier anticipate care needs and provide them before the resident become resident. Explain/reinforce why behavior is unacceptable. Interven- estigate/observe need for psychological/psychiatric support. Provide	es overly stressed, if e as needed to protect	
	by resident/responsible party as or provide a safe living environment patient.	rdered by the physician. Report to physician changes behavioral sta for resident daily. Discuss compliancy and potential results of non-	tus. Attempt to -compliancy with	
	concern regarding CR#1's PICC li Record review of CR #1's progress	s notes dated [DATE] at 10:18PM revealed in part, Resident appetit	te has decreased, and he	
	period of time with a syringe and nurse and resident stated he did no in mental status, he was slurring h 88, 20, 97.5, 98%. Resident breath	sident was observed by a Physical Therapy assistant sitting on the to needle on the floor next to him. Resident was asked where the syrir ot know what the charge nurse was talking about. Resident appeared his speech and stated that he was feeling dizzy. Resident vitals were hing was even and unlabored with no complaints of shortness of pre-	nge came from by charge d to have slight change obtained ,[DATE], eath. Resident received	
	something to eat, as of 10:30PM returned. Resident did not receive	nt left off premises at 7:32PM, stated he was going out with his fam resident still has not returned. Informed 10PM-6AM shift nurse that any 8:00PM medications. Will continue to monitor. Progress note evealed there was no further follow up on this incident by the facility	resident had not was signed by LVN #3.	
	Interview on [DATE] at 1:00PM, I [DATE]. She said she was on brea	LVN #3 confirmed she completed the note about the syringe being ak around noon and when she returned another nurse told her about I she had placed it in the med room for her to examine. She examine	the needle being found in	

FORM CMS-2567(02-99) Event ID: YL1011 Previous Versions Obsolete

			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED	
CORRECTION	NUMBER 675080	b. wind	10/08/2018	
NAME OF PROVIDER OF SU		STREET ADDRESS, CITY,	, STATE, ZIP	
THE VOSSWOOD NURSING	NG CENTER 815 S VOSS RD HOUSTON, TX 77057			
For information on the nursing	g 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 0740	(continued from page 8)			
Level of harm - Immediate jeopardy	his history of drug use. She said after she examined the needle she went to CR #1's room and observed him coming out of the restroom and he complained of being dizzy and was slurring his speech. She assisted him to the bed and asked him what was			
Residents Affected - Few	restroom and he complained of being dizzy and was slurring his speech. She assisted him to the bed and asked him what was going on. He denied having the syringe and said he didn't know what she was talking about. She took his vitals and she felt they were normal for him. She went to the nurse's station and the weekend unit manager (RN #1) was there and already knew of the incident. She said they then called the on-call NP and was instructed not to do any labs and to monitor the resident for changes and if there are changes to send to the hospital. LVN #3 reported she worked 6AM - 10PM on Saturday and Sunday and did not observe any changes or concerns in the resident during that time. She revealed she was very concerned about him			
	Record review of CR #1's written Record review of CR #1's transcri	nonitored him and kept track of where he was. physician's orders [REDACTED]. [DIAGNOSES REDACTEI] bed physician's orders [REDACTED]. s notes dated [DATE] at 10:43PM revealed in part, Resident re		
	NAME]	•	_	
	line	TED], heel wound and amputated great toe. No adverse reactio	, ,	
	Resident complained of abdomin	with blood, will need to be changed. PICC line is patent, with al pain and diarrhea, gave Questran to aid with loose stools. Re ist when needed. Resident receiving PT/OT skilled services, resident receiving PT/OT skilled services.	esident is continent of bowel	
		ss notes dated [DATE] at 3:55pm revealed the resident was vis resentative. Note further revealed per evaluation the resident w ation was pending.		
	around 6:30AM on [DATE]. Cod Emergency Medical Services (EM	ident report dated [DATE] revealed CR #1 was found unresponde Blue was initiated and 911 was called. Cardiopulmonary resuMS) arrived and took over and pronounced the resident at 7:07.	uscitation (CPR) was started. AM. The EMS note syringe with	
	Police Department (HPD) was no on day shift 6am - 2pm.	olack plastic spoon with small brown colored rock like substance stified and on scene at 7:35AM as well as Medical Examiner as	s of 9:19AM. Incident was observed	
	rounds on CR #1 in room [ROOM went back to the 5th floor where but noted the Medication Admini	in statement dated [DATE] revealed she came to the 2nd floor A NUMBER] and LVN #2 stated she saw him go down in the e she was assigned. She returned to the 2nd floor to administer ar stration Record [REDACTED]. The night nurse and morning r	elevator to go outside and smoke. She ny 6:00AM meds for CR #1	
	around 6:30AM. LVN #1 said she	back to her 5th floor station. LVN #1 confirmed she was the nurse to discover CR #1 unres e had just come onto her shift and was headed to CR #1's room he floor. She went into the room and found the resident unresp	when CNA #1 came out of the room	
	floor lying in fetal position. She code blue. Resident was pulled or presented signs as if he had been	called out to the resident and he did not respond, she checked hat into room area, CPR was started and 911 was called LVN # ying there for a while, she did not elaborate. She further said shis cell phone to notify family and found a syringe. She said the	is pulse and called a 1 said the resident body she raised up the	
	plastic spoon and some brown rounickel size blood spot on it and the wrong when she saw the light on slept in until around 11:00AM. L	ck like substance that she suspected to be heroin. There was als he hot water was running in the sink when she entered the room in the resident's room because the resident was not usually aw VN #1 said she had no idea the resident had a history of [RED. rt of any concerns or incidents for CR #1. She added the resident	so a paper towel with a n. She felt something was ake at that time, he usually ACTED]. The nurse from the	
	often leave out of the facility to g Interview on [DATE] at 5:59AM, ([DATE]). CNA #2 said she mad	o and smoke. CNA #2 said she worked 10PM - 6AM shift on the 2nd floor t e rounds around 10:00PM and the resident was not in his room	the night before CR #1 was found and she assumed he was out	
	elevator between the time of 1:30 into his room and closed the door resident's room the rest of the nig	t the facility to go and smoke. The next time she saw the reside AM - 2:30AM. CR #1 did not greet them at the nurses' station. She did not see the resident for the rest of the night. She did r ht because he does not like to be bothered when his door was c	as he sometimes did and went not go into the closed. She said she could	
	or past issues with drugs. CNA # Interview on [DATE] at 7:30AM, assessment. The social worker sa	ality due to him being a quiet person. CNA #2 was unaware of 2 added the resident would often leave out of the facility throug the social worker said CR #1 did not self-disclose a history of id the resident did not present behaviors for her to suspect curro	ghout the night to go smoke. drug use to her during her ent issues with substance	
	non-smoke free facility. The soci (IDT) and Nursing Services were	sed. She had spoken with the resident on [DATE] concerning I al worker found a smoking facility to accept the resident and th aware. The incident on [DATE] with CR #1 being found with r morning meeting after he had passed on [DATE]. Due to her	ne Interdisciplinary Team a syringe and needle was not	
	incident she did not reassess the r Phone interview on [DATE] at 9: the DON instructed her to do but	resident for drug abuse or make any referrals. 15AM, LVN #2 said she came to work Monday night ([DATE] did make observations of him in his room while walking the harmonic management of the same of	alls. She observed CR #1 in	
	between 2:00AM - 2:30AM. She said she then called the nurse assi	on his bed due to his door being open. She observed CR #1 let did med pass around 4:00AM and saw CR #1 lying in his bed igned to him (LVN #4) to give him his meds and LVN #4 said to fresident having history of substance abuse, the incident of a	due to the door being open. LVN #2 she would be down in a minute.	
	would often leave out of the facil outside.	for the resident to be monitored for suspicions of drug use. LV ity throughout the night without signing out, it was always assu	umed he was smoking	
	his room and his behavior when s the resident was yelling and screa remove the cigarettes and lighter.	the Unit Manager said LVN #2 had called her around 3:00AM she confronted him. She had LVN #2 put her on speaker and at uning refusing to listen. She told LVN #2 to leave the room and She texted the DON and Administrator to determine if the polk from the nurses they were able to retrieve the cigarettes and results.	tempted to talk to CR #1, but d get another nurse to ice should be called. Before	
	about his fighting the staff. She c resident had already fallen asleep added she was shocked by his bel often go outside to smoke or leav	ame in shortly after 3:00AM to see the resident and address the The DON spoke with the resident when he woke up later in the havior and she had never saw the resident act in that way. She a e the premises with a woman. She said CR #1 was non-compli-	e situation but the he day. The Unit Manager also confirmed CR #1 would	
	had a few issues with his PICC li evidence. She questioned the resi	igning out. I, the Unit Manager said she was aware CR #1 had a history of ne and she wondered if he was messing with it but did not wan dent on one occasion where she found the PICC line bloody as a came in earlier had flushed the line and caused the mess. The	t to assume or accuse without if it had been tampered with	
	aware of the incident that happen after he was found deceased on [I Interview on [DATE] at 12:45PM asked her to step out to the hall. T	ed over the weekend ([DATE]) with the resident being found v DATE]. , CNA #3 said around 12:00PM on [DATE] she was in a room The nurse asked where CR #1 was when she went to pass his lu	with a syringe and needle until assisting with feeding when a nurse unch tray. They both went	
	paper with blood on it. CR #1 tole from off the floor before they left	e bathroom door and observed him on the toilet with a syringe d them to get out because he had diarrhea. The nurse (LVN#5) the room. She added that when she went to pass the lunch tray he had gone downstairs to smoke.	was able to grab the syringe	
		VN #4 via phone on [DATE] at 1:20PM and [DATE] at 5:00PM	A, there was no response and	
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FORM CMS-2567(02-99) Previous Versions Obsolete

		1	OMB NO. 0938-0391	
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		
CORRECTION	NUMBER	B. WING	10/08/2018	
	675080			
NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP				
THE VOSSWOOD NURSING		815 S VOSS R		
HOUSTON, TX 77057				
For information on the nursing	home's plan to correct this deficien	icy, please contact the nursing home or the state su	irvev agency.	
(X4) ID PREFIX TAG	1	DEFICIENCIES (EACH DEFICIENCY MUST BI		
(-1., -111.				
F 0740	(continued from page 9)			
	Attempt was made to contact LVN #5 via phone on [DATE] at 1:25PM, there was no response and voicemail was left with no			
Level of harm - Immediate				
Jeopardy				
Residents Affected - Few	OR LSC IDENTIFYING INFORMATION) (continued from page 9)			
	c. Řoom rounds completed by dep ,[DATE] times weekly. Completed [DATE] 1. Continued Education of Staff a	noking history or substance abuse history the care partment heads and no potentially hazardous items above		
		cation as per above for history of smoking or substance abuse		
	4. Audited Sharps containers5. Staff will not be allowed to retule Facility practice:	urn to work until education has been completed		
	Facility liaisons conduct bed si	de screenings and follow the facility capability gri	d to determine the appropriateness of	
	2. At the time of the bed side scre	 facilities ability to meet their needs. ening the information is forwarded to the facility to the 4 hour report and in shift to shift communic phol use, smoking 		
F 0835		mer that enables it to use its resources effective	ly and	
	efficiently.			
Level of harm - Immediate jeopardy Residents Affected - Few		IS HAVE BEEN EDITED TO PROTECT CONFI view, the facility failed to be administered in a ma		
1 CW	1			

FORM CMS-2567(02-99) Previous Versions Obsolete

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA IDENNTIFICATION À. BUILDING B. WING ____ 10/08/2018 NUMBER 675080 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP THE VOSSWOOD NURSING CENTER 815 S VOSS RD HOUSTON, TX 77057 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0835 (Continued... min page 10) resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 14 residents (CR #1) reviewed for resident administration in that: Level of harm - Immediate The Administrator failed to develop and implement policy and procedure for a resident admitted to the facility who was non-compliant with smoking in a non-smoking facility

The Administrator failed to have policy and procedure in place for suspected illicit drug use in the facility.

The DON failed to train nursing staff on how to monitor and supervise resident with a possible illicit drug use in the jeopardy Residents Affected - Few facility. The DON failed to ensure nursing staff were made aware of CR#1's history of illicit drug use and failed to ensure staff received adequate communication of recent incident of suspected drug use in the facility by CR#1 for which supervision/monitoring was required and ordered. CR #1 was found dead in his bathroom with a syringe and needle next to him and heroin on the bathroom sink.

An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was lowered on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated because the facility was continuing to train staff and monitor the effectiveness of the Plan of Removal. These failures affected one closed record who died . Findings include: TX 779/Intake # Interview on [DATE] at 4:00PM, the Administrator and DON said the company had Liaisons who go into hospitals to assess resident and clear them to be admitted to the facility. The Administrator and DON when asked said CR#1 was admitted to the facility despite his history of substance abuse due to no indication the resident was currently using drugs. The Administrator and DON when asked said CR#1 had no care plan for risks of substance abuse upon his admission because facility did not feel the resident presented concerns. There were also no smoking assessments completed or care plan addressing smoking for the resident because the facility was non-smoking. The Administrator said staff were aware of the resident leaving the facility to smoke and him leaving the facility for extended periods of time. The DON said she attempted to counsel with the resident on checking out of the facility, but he continued to be non-compliant. The Administrator and the DON said after the incident on [DATE] when CR #1 was found with a syringe and needle, they responded accordingly by notifying the Physician and following the orders to monitor the resident. They confirmed CR #1's care plan was not updated to reflect the incident, there were no assessments or referrals made, and there were no additional interventions put in place for the resident. The DON said there were no in-services completed for staff concerning signs of substance abuse or how to monitor for substance abuse issues. The DON said the resident was being monitored and there were no further concerns, signs, or changes after the incident that prompted them to do anything else. The DON gave no specifics on how the staff were monitoring the resident and she said the Physician did not specify that in her order. The DON said she knew the resident's vitals were taken every day and there was a nurse (LVN #3) on the weekend shift who closely monitored the resident by keeping track of where he was going and his status when he returned. The DON agared there was a break in communica the syringe and the residents drug history, the resident was properly monitored and presented no changes to cause them to initiate any other interventions initiate any other interventions.

Interview on [DATE] at 9:32AM the Administrator said the facility has liaison's in who go to hospitals to evaluate residents for admission to the facility. If the liaisons approve the resident for admission, the file is sent to the facility for facility staff to review. After a resident is admitted the facility has interdisciplinary team (IDT) meetings to evaluate the resident and establish a care plan in conjunction with the medical physician. The Administrator said he monitors staff through morning meetings, weekly meetings with department heads, and doing monitoring rounds. He ensures the competency of staff with skill check offs and annual review of job descriptions and performance review. The facility ensures the effectiveness of the facility process through Quality Assurance committee meetings that meet monthly. The Administrator identified the medical physician, medical director, psychiatric services, psychological services, and corporate personnel as facility resources. The Administrator when asked what he thought lead to the immediate jeopardy said he could not speak on what led to the incident with CR #1 because it had just happened on [DATE]. He said the situation was still being investigated so he is part shed to say if and how there was a failure investigated so he is not able to say if and how there was a failure.

Interview on [DATE] at 9:46AM, the DON said the staff were not previously in-serviced on signs or symptoms of drug use. Interview on [DA 1E] at 9:40AM, the DON said the staff were not previously in-serviced on signs or symptoms of drug use. After the incident the staff were in-serviced over reviewing resident clinical record for history, 24-hour report, abuse/neglect, signs and symptoms of drug use, monitoring residents, and checking out process. The DON said residents will now be evaluated when they return to the facility and checked for paraphernalia being brought in. Residents who come in with substance abuse issues should have been identified before admission and presented to the circle of service. The IDT team then should have gone to the resident's bedside and addressed the identified history and came up with a plan of care. The DON was not sure how the incident came about because the situation was still under investigation. She added the facility are evaluating our understanding or resident rights while putting safety first. Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED].

Record review of the facilities Pre-Admission Assessment for CR #1 dated [DATE] revealed he was admitted to local hospital on [DATE]. The assessment revealed the resident was homeless living in his car before admission to the hospital. His admitting [DIAGNOSES REDACTED]. Further review of the assessment revealed the resident was accepted into the facility. There were no additional notes on the assessment addressing the substance abuse or use of cigarettes.

Record review of CR #1's History and Physical (H&P) dated [DATE] completed by NP, revealed a social history stating, current every day smoker, drinks beer ,[DATE] times per week, no illicit drug abuse. CR#1's H&P revealed review of Miscellaneous labs stating, urine drug screen [DATE] positive with opiates. The H&P summary of Plans did not address the resident's positive drug screen, history of drug use, or current cigarette use.

Record review of CR #1's Admissions Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Further review of the MDS revealed CR #1 had no current Tobacco use. use.

Record review of CR #1's hospital record dated [DATE] revealed a social history - He uses heroin and has a history of [MEDICATION NAME] use in the past. He smokes cigarettes. He denies alcohol use. Urine drug screen was positive for opiates. The Impression was At this time, I strongly suspect the fever is related to the fracture and also possible drug fevers. Record review of CR #1's record revealed no baseline care plan on admission on file.

Record review of CR #1's record revealed no care plan addressing the resident's history or risk of substance abuse and problems following educations. smoking following admission.

Record review of CR #1's progress notes dated [DATE] at 11:14AM revealed, Doctor here to see resident with new orders for Intravenous Antibiotics (IVABT) and labs. Pharmacy notified of peripherally inserted central catheter (PICC) placement and orders faxed to pharmacy. Resident was informed of IVABT for [MEDICAL CONDITION] lower extremities. Note was written by LVN#1.

Record review of CR #1's progress notes dated [DATE] at 10:16AM revealed, Attempted to flush and hang IVABT via PICC at 7:00AM. Unable to flush. Assessed IV and noted rubber cap off PICC line site. Unit manager assessed also and noted. PICC line dislodged right upper arm. Call placed to pharmacy and request for PICC line reinsertion and will send nurse out. Resident informed IVABT will be given after insertion. Note was written by LVN#1.

Record review of CR #1's progress notes dated [DATE] at 2:05PM revealed, RN here to reinsert PICC line at 12:00PM. Orders for STAT chest x-ray for placement prior to restarting IVABT. Doctor here and informed of PICC line out and residents Physician also notified. X-ray ordered with number 011. Resident aware. [MEDICATION NAME] with-held d/t bleeding at insertion site. Note was written by LVN#1.

Record review of CR #1's progress notes dated [DATE] referred to a late entry from [DATE] 10PM-6AM. The note revealed on [DATE] around 2:30AM, LVN #2 smelled a cigarette odor. She followed the smell and went to CR #1's room where she observed him sitting on his bed smoking a cigarette. She politely informed him that smoking was not permitted in residents' room.

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 675080 If continuation sheet Previous Versions Obsolete Page 11 of 14

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTIO)N	(X3) DATE SURVEY
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING		COMPLETED 10/08/2018
	675080			
NAME OF PROVIDER OF SU	PPLIER	rz	ΓREET ADDRESS, CITY, ST.	ATE, ZIP
THE VOSSWOOD NURSING	G CENTER		15 S VOSS RD	
For information on the nursing	home's plan to correct this deficier	cy, please contact the nursing home	or the state survey agency	
(X4) ID PREFIX TAG	1	DEFICIENCIES (EACH DEFICIEN		Y FULL REGULATORY
	OR LSC IDENTIFYING INFOR	MATION)		
F 0835 Level of harm - Immediate jeopardy	LVN #2 called the unit manager	g and yelling at her saying, What the and she instructed her to get another second nurse who also said he could	nurse and get the cigarettes aw	ay from the resident.
Residents Affected - Few	check his drawer for cigarettes at punched the nurse and began hitt objects while they were asking the some medication that were in the	nd lighter to avoid accidents and dang ing him in the head with the phone. The resident to stop and calm down. The drawer. The staff left out of the room	ger. The other nurse reached for The resident continued to curse the nurse was able to discover a m and the resident followed the	or the drawer and CR #1 e and hit the nurse with pack of cigarettes and em to the nurse's
	Phone interview on [DATE] at 9: [DATE]	nd curse. LVN #2 called the Physicia 08AM, LVN #2 confirmed she was t I - 6AM shift. She said she smelled s	he nurse who observed CR #1	smoking in his bedroom on
	and told him he could not smoke stood in the doorway while tellin	on the end of the bed with a cigarette in the facility and he began to yell at g her what was going on. The unit m ling and cursing. The unit manager in	nd curse at her. She then called nanager attempted to talk to the	the unit manager and resident over the
	cigarettes and lighter. She got an began to fight the male nurse and	other male nurse (RN#2) and they att hit him with the phone and other ob he later wrote up what happened and	tempted to remove the cigarette ejects nearby. They recovered s	es and the resident ome cigarettes and
	Record review of RN #1's written was immediately informed of a s nurse (LVN#2) told her the resid behaviors at that time. Later duri	statement dated [DATE] revealed w moking incident that had taken place ent was still there and per the 6AM - ng the 6AM -2PM shift it was brougl 's bathroom floor. RN #1 confirmed	with CR #1 and had led to con 2PM nursing staff the resident ht to her attention that an unfar	mbative behavior. The night did not present anymore niliar needle, syringe
	facility. The nurse assigned to the called the DON and left a voicen to have the resident sent out to be	e resident (LVN #3) also confirmed to nail. RN#1 instructed LVN #3 to call e evaluated or treated. She further not production during her shift. RN #1 wrote	the syringe was not used by her the physician and request for l ted LVN #3 denied the residen	r or on her cart. She labs for a drug panel or t presented any
	she witnessed LVN #3 suggest a directives to monitor for change noted to be stable with no behavi	not answering the phone. During this drug panel or for the resident to be so in condition and if so to discharge to ors. Shortly after staff spoke with the	ent out to the hospital. The on- the hospital. During that time to e on-call provider the DON rep	call provider gave the resident was lied to the text and
	intentions were, and to get family present any cause for concern. O and he also said to monitor reside	ed if the device was removed, use cay involved. The resident was closely in Sunday morning [DATE] the Adment, report change, and send out if never the control of the contr	monitored for the rest of the winistrator was notified when he beded	eekend and did not was noted in the building
	behavior- smoking in his room. Topen, and some [MEDICATION smoke-free and he was not allow discharge. Resident denied smok smoke. He was also told he could	is notes dated [DATE] at 2:27PM, re The Resident denied hitting anyone at NAME] pills he kept for his own use d to smoke anywhere on the premis ing in the room and said he had just of a not keep medications in room and i tring to discharge next week, and he	nd said they found a pack of ci e. The resident was educated a ses and failure to follow the pol come from smoking outside an f he felt he needed something t	garettes that were not bout the facility being icy could result in d that's why he smelled of the Physician would order
	combativeness towards staff and Record review of CR #1's Care P exhibiting periods of manipulatic goal was, Resident will experien [DATE]. The approaches were to reasonable, discuss behavior with the rights and safety of other. In by resident/responsible party as of	ishes. Residents care plan was update taking medication not prescribed by an dated [DATE] revealed resident is combativeness and verbal aggressice minimal adverse effects from non-o, anticipate care needs and provide the resident. Explain/reinforce why belrestigate/observe need for psychologiordered by the physician. Report to plet for resident daily. Discuss complian	the Physician. s at risk for non-compliancy w ion towards staff, as reported b -compliance through next revie hem before the resident becom navior is unacceptable. Interver ical/psychiatric support. Provid hysician changes behavioral st	ith smoking in the room, y nursing staff. The ww, with a target date of es overly stressed, if he as needed to protect le services if desired atus. Attempt to
	patient.	revealed it did not address CR#1's d	•	
	concern regarding CR#1's PICC		,	5
	has not been eating his meals. Reperiod of time with a syringe and nurse and resident stated he did r in mental status, he was slurring 88, 20, 97.5, 98%. Resident brea Physical therapy services. Resides something to eat, as of 10:30PM returned. Resident did not receiv. Further review of CR#1's record in the state of the state o	sident was observed by a Physical T needle on the floor next to him. Res tot know what the charge nurse was t his speech and stated that he was fee thing was even and unlabored with nent left off premises at 7:32PM, state- resident still has not returned. Inforn e any 8:00PM medications. Will con- evealed there was no further follow	herapy assistant sitting on the t sident was asked where the syritalking about. Resident appeare ling dizzy. Resident vitals were o complaints of shortness of br d he was going out with his far ned 10PM-6AM shift nurse tha tinue to monitor. Progress note	toilet for an extended nge came from by charge do to have slight change e obtained ,[DATE], reath. Resident received nily member to get tt resident had not was signed by LVN #3.
	[DATE]. She said she was on brothe restroom with the resident an confirmed it was not a needle that off. LVN #3 began to get emotion	LVN #3 confirmed she completed that around noon and when she return d she had placed it in the med room it was used in the facility and said it anal as she explained how she had a cafter she examined the needle she we	ned another nurse told her about for her to examine. She examina appeared to be old due to the malose relationship with the resid	t the needle being found in need the needle and umbers being worn ent and was unaware of
	restroom and he complained of b going on. He denied having the s they were normal for him. She w of the incident. She said they the for changes and if there are chan and did not observe any changes after the incident, so she closely Record review of CR #1's written	eing dizzy and was slurring his speed yringe and said he didn't know what ent to the nurse's station and the wee n called the on-call NP and was instrages to send to the hospital. LVN #3 ro or concerns in the resident during the monitored him and kept track of whe physician's orders [REDACTED]. [1	ch. She assisted him to the bed she was talking about. She too skend unit manager (RN #1) was ucted not to do any labs and to reported she worked 6AM - 10I at time. She revealed she was were he was. DIAGNOSES REDACTED].	and asked him what was k his vitals and she felt as there and already knew monitor the resident PM on Saturday and Sunday
	Record review of CR #1's progres NAME]	ibed physician's orders [REDACTED is notes dated [DATE] at 10:43PM re	evealed in part, Resident receiv	_
	line to upper right arm, dressing dirty Resident complained of abdomin	TED], heel wound and amputated gr with blood, will need to be changed al pain and diarrhea, gave Questran t	. PICC line is patent, with [ME to aid with loose stools. Reside	EDICATION NAME] lock.
	with aid of walker. Record review of CR #1's progre	ist when needed. Resident receiving ss notes dated [DATE] at 3:55pm rev resentative. Note further revealed pe	vealed the resident was visited	for an admission
	for admission, insurance authoriz Record review of the facility's inc around 6:30AM on [DATE]. Coo		CR #1 was found unresponsive lled. Cardiopulmonary resuscit	e on his bathroom floor ation (CPR) was started.
	Emergency Medical Scivices (El	and following and box over and prono	aneca me resident at /.U/AM.	The Livis now syringe will

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 675080 If cor Previous Versions Obsolete Page

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING ____ 10/08/2018 675080 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP THE VOSSWOOD NURSING CENTER 815 S VOSS RD HOUSTON, TX 77057 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0835 clear substance next to sink and black plastic spoon with small brown colored rock like substance in front of sink. Houston Police Department (HPD) was notified and on scene at 7:35AM as well as Medical Examiner as of 9:19AM. Incident was observed Level of harm - Immediate no day shift 6am - 2pm.

Record review of LVN #4's written statement dated [DATE] revealed she came to the 2nd floor on [DATE] around 2:00AM to make rounds on CR #1 in room [ROOM NUMBER] and LVN #2 stated she saw him go down in the elevator to go outside and smoke. She went back to the 5th floor where she was assigned. She returned to the 2nd floor to administer any 6:00AM meds for CR #1 but noted the Medication Administration Record [REDACTED]. The night nurse and morning nurse were notified the patient did jeopardy Residents Affected - Few but noted the Medication Administration Record [REDACTED]. The night nurse and morning nurse were notified the patient did not have 6:00AM meds and went back to her 5th floor station.

Interview on [DATE] at 5:47AM, LVN #1 confirmed she was the nurse to discover CR #1 unresponsive in his restroom on [DATE] around 6:30AM, LVN #1 said she had just come onto her shift and was headed to CR #1's room when CNA #1 came out of the room and told her the resident was on the floor. She went into the room and found the resident unresponsive on the bathroom floor lying in fetal position. She called out to the resident and he did not respond, she checked his pulse and called a code blue. Resident was pulled out into room area, CPR was started and 911 was called. LVN #1 said the resident body research clause as if he had been lying there for a while, she did not alshorate. code blue. Resident was pulled out into room area, CPR was started and 911 was called. LVN #1 said the resident body presented signs as if he had been lying there for a while, she did not elaborate said she raised up the resident's shirt in attempts to find his cell phone to notify family and found a syringe. She said there was also a black plastic spoon and some brown rock like substance that she suspected to be heroin. There was also a paper towel with a nickel size blood spot on it and the hot water was running in the sink when she entered the room. She felt something was wrong when she saw the light on in the resident's room because the resident was not usually awake at that time, he usually slept in until around 11:00AM. LVN #1 said she had no idea the resident had a history of [REDACTED]. The nurse from the right shift did not give her a report of any concerns or incidents for CP. #1. She added the resident was a smoker and would often leave out of the facility to go and smoke.

Interview on [DATE] at 5:59AM, CNA #2 said she worked 10PM - 6AM shift on the 2nd floor the night before CR #1 was found ([DATE]). CNA #2 said she made rounds around 10:00PM and the resident was not in his room and she assumed he was out smoking because he often left out the facility to go and smoke. The next time she saw the resident he was out smoking because the often left out the facility to go and smoke. The next time she saw the resident he was coming out the elevator between the time of 1:30AM - 2:30AM. CR #1 did not greet them at the nurses' station as he sometimes did and went elevator between the time of 150/AM - 2:50/AM. CR #1 did not greet them at the nurses station as he sometimes did and we into his room and closed the door. She did not see the resident for the rest of the night. She did not go into the resident's room the rest of the night because he does not like to be bothered when his door was closed. She said she could not speak on the resident's personality due to him being a quiet person. CNA #2 was unaware of resident having any current or past issues with drugs. CNA #2 added the resident would often leave out of the facility throughout the night to go smoke. or past issues with drugs. CNA #2 added the resident would often leave out of the facility throughout the night to go smoke. Interview on [DATE] at 7:30AM, the social worker said CR #1 did not self-disclose a history of drug use to her during her assessment. The social worker said the resident did not present behaviors for her to suspect current issues with substance abuse, therefore it was not addressed. She had spoken with the resident on [DATE] concerning his request to discharge to a non-smoke free facility. The social worker found a smoking facility to accept the resident and the Interdisciplinary Team (IDT) and Nursing Services were aware. The incident on [DATE] with CR #1 being found with a syringe and needle was not brought to her attention until their morning meeting after he had passed on [DATE]. Due to her being unaware of the incident she did not reassess the resident for drug abuse or make any referrals.

Phone interview on [DATE] at 9:15AM, LVN #2 said she came to work Monday night ([DATE]) and did not go into CR #1's room as the DON instructed her to do but did make observations of him in his room while walking the halls. She observed CR #1 in his room around 10:05PM sitting on his bed due to his door being open. She observed CR #1 leaving out of the elevator between 2:00AM - 2:30AM. She did med pass around 4:00AM and saw CR #1 lying in his bed due to the door being open. LVN #2 said she then called the nurse assigned to him (LVN #4) to give him his meds and LVN #4 said she would be down in a minute. LVN #2 added she was not aware of resident having history of substance abuse, the incident of resident being found with a syringe on [DATE], or the orders for the resident to be monitored for suspicions of drug use. LVN #2 added the resident would often leave out of the facility throughout the night without signing out, it was always assumed he was smoking outside.

Interview on [DATE] at 9:50AM, the Unit Manager said LVN #2 had called her around 3:00AM and told her about CR #1 smoking in his room and his behavior when she confronted him. She had LVN #2 put her on speaker and attempted to talk to CR #1, but the resident was yelling and screaming refusing to listen. She told LVN #2 to leave the room and get another nurse to remove the cigarettes and lighter. She texted the DON and Administrator to determine if the police should be called. Before they could respond she heard back from the nurses they were able to retrieve the cigarettes and medications and was told about his fighting the staff. She came in shortly after 3:00AM to see the resident and address the situation but the resident had already fallen asleep. The DON spoke with the resident when he woke up later in the day. The Unit Manager added she was shocked by his behavior and she had never saw the resident act in that way. She also confirmed CR #1 would often go outside to smoke or leave the premises with a woman. She said CR #1 was non-compliant with signing out and she would often get onto him about signing out.

Interview on [DATE] at 10:20AM, the Unit Manager said she was aware CR #1 had a history of [REDACTED]. She said the resident had a few issues with his PICC line and she wondered if he was messing with it but did not want to assume or accuse without evidence. She questioned the resident on one occasion where she found the PICC line bloody as if it had been tampered with and CR #1 claimed the nurse who came in earlier had flushed the line and caused the mess. The Unit Manager said she was not surgested the incident that he present out that have located the line and caused the mess. The Unit Manager said she was not surgested the incident that he present out that have located (IDATE) with the surgested the line and days with a surgest each available that the present of the surgested that the present of the problem of the p and CR #1 claimed the nurse who came in earner had nushed the line and caused the mess. The Unit Manager said she was not aware of the incident that happened over the weekend ([DATE]) with the resident being found with a syringe and needle until after he was found deceased on [DATE].

Interview on [DATE] at 12:45PM, CNA #3 said around 12:00PM on [DATE] she was in a room assisting with feeding when a nurse asked her to step out to the hall. The nurse asked where CR #1 was when she went to pass his lunch tray. They both went into CR #1's room and opened the bathroom door and observed him on the toilet with a syringe on the floor wrapped in toilet paper with blood on it. CR #1 told them to get out because he had diarrhea. The nurse (LVN#5) was able to grab the syringe from off the floor before they left the group. She added that when she went to pass the lunch tray earlier the resident was from off the floor before they left the room. She added that when she went to pass the lunch tray earlier the resident was not in the room and she assumed he had gone downstairs to smoke.

Attempts were made to contact LVN #4 via phone on [DATE] at 1:20PM and [DATE] at 5:00PM, there was no response and was left with no return phone calls. Attempt was made to contact LVN #5 via phone on [DATE] at 1:25PM, there was no response and voicemail was left with no return phone calls.

Record review of CR #1's clinical record revealed no documentation of labs, assessments, or referrals addressing substance abuse or resident's ability to smoke outside the facility since his admission. There was also no check out log to indicate when the resident had left and returned to the facility or evidence the resident had been counseled about it.

Interview on [DATE] at 3:00PM, CR #1's Physician said she came into the facility on [DATE] and discontinued an order for [REDACTED]. She did not address the situation that happened on [DATE] with the syringe during her visit because she was unaware of the incident. She was not told about the incident until the morning meeting on [DATE] after the resident had passed. She confirmed she had now talked to her on-call NP who was contacted about the incident on [DATE] and she confirmed she gave orders to monitor the resident for changes and send out if there were changes. She added she was also not aware of the resident combative behavior with staff when he was found to be smoking in his room on [DATE], she was only told the resident was smoking cigarettes and [MEDICATION NAME] were retrieved from his room.

Record review of Houston Police Department Report dated [DATE] at 7:11AM revealed an offense titled Death - Poison/Drugs. CR #1 was identified as the complainant in the report. The Brief Summary revealed, The complainant was found deceased in nursing home by the attending nurse. A syringe with needle and a small amount of heroin was also found near the body. The report further revealed Houston Fire Department was on the scene and announced time of the death at 7:07AM, the complainant appeared to have been deceased for at least 2 hours because he was stiff and rigory mortis had started to set in. The reportee was listed as LVN #1, her statement revealed she found the resident deceased in bathroom around 6:30AM. She return phone calls. appeared to have been decased for at least 2 hours because he was stiff and rigor involves had stated to set in. The reportee was listed as LVN #1, her statement revealed she found the resident deceased in bathroom around 6:30AM. She alerted other staff to come help her, so they could initiate CPR and 911 was called. She stated she found a syringe with needle and a small amount of heroin on the sink of the bathroom and she suspected the complainant was shooting heroin prior Record review of the facility's Administrative Responsibility Policy (Revised ,[DATE]) revealed in part, 2. The Executive Director will be responsible for supervision of policy implementation and formulation of new policies and programs as advised by the governing body, consultants, staff, and members of the board of directors. 3. The Executive Director will be

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED:1/21/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING 10/08/2018 675080 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 815 S VOSS RD HOUSTON, TX 77057 THE VOSSWOOD NURSING CENTER For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 13) responsible for implementing facility policies and formulating departmental policies with advice and counsel from the consultants, medical staff, and departmental staff. He/she will administer and conduct all aspects of the policies and programs with the framework provided. 4. The Executive Director will be responsible for all implications of the program operations as it effects the residents, staff, families, and community. 8. The Executive Director is delegated by the Governing Body to have full responsibility for the daily operations of the facility. Record review of the Job Description for F 0835 Level of harm - Immediate jeopardy Residents Affected - Few

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