STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675080	A. BUILDING _____ B. WING _____	10/08/2018

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, 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. 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 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 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. 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. 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 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 [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.

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

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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 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 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 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 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. 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 [DATE]. 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 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 line 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. 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 on 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 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 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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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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 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 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 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 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. 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 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 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 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 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 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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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) 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: ,[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 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 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- 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) 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 2. Completed current resident education as per above 3. Audited new admission charts for history of
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards 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 drugs. CR#1's baseline care plan and admission comprehensive assessment care plan did not address CR#1's history of illicit drug use and smoking. 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 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. 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.

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	675080	A. BUILDING _____ B. WING _____	10/08/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VOSSWOOD NURSING CENTER	815 S VOSS RD HOUSTON, TX 77057

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) 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 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 [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. 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 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 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 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. 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 [DATE]. 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 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 line 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. 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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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 on 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 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 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 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 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 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 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. 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 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 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 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

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F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 6) 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 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 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 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 Safety Management Program policy (Last revised [DATE]) revealed in part, The facility is committed to a safety management program designed to provide a physical environment free of hazards, manage staff activities, and minimize the risk of human injury. It shall be directed to the safety of all associates, residents, and visitors interacting with the facility. The Administrator and the DON were notified of the Immediate Jeopardy on [DATE] at 4:15PM due to the above failures. A Plan 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- 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) 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 2. Completed current resident education as per above 3. Audited new admission charts for history of smoking or substance abuse 4. Audited Sharps containers 5. Staff will not be allowed to return to work until education has been completed Facility practice: 1. 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 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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** > 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]. 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: 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]. 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.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0740 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) 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. 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 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 [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. 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 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 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 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. 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 [DATE]. 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

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F 0740 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) 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 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 line 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. 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 on 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 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 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 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 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 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 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. 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.

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F 0740 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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 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 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 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 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 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 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 Behavioral Health Management policy (Last Revised [DATE]) revealed in part, Purpose, to promote safety, attain highest practicable mental/psychosocial well-being and reduce behavioral related events. Further review revealed in part, Providing behavioral healthcare and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualizes approaches to care are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident distress or loss of abilities. The Administrator and the DON were notified of the Immediate Jeopardy on [DATE] at 4:15PM due to the above failures. A Plan 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- 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) 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 2. Completed current resident education as per above 3. Audited new admission charts for history of smoking or substance abuse 4. Audited Sharps containers 5. Staff will not be allowed to return to work until education has been completed Facility practice: 1. 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
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on interview, and record review, the facility failed to be administered in a manner that enabled it to use its

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from 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: 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 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 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 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 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. 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. 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 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. 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.

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) 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 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 [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. 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 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 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 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. 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 [DATE]. 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 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 line 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. 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

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 12) 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 on 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 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 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 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 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 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 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. 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 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 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 to his death. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675080	A. BUILDING _____ B. WING _____	**10/08/2018**

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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