STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455802	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPANISH MEADOWS	**440 E RUBEN TORRES BLVD BROWNSVILLE, TX 78520**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, for two Residents (R#1 and R#2) of five residents reviewed for care plans in that: 1) R#1's care plan did not address a pressure injury of the sacral region. 2) R#2's care plan did not address a Stage 2 pressure injury of the sacral region until the injury deteriorated to a Stage 3 pressure injury. These failures could place residents at risk for not receiving necessary care and services. The findings were: 1) Record review of R#1's Admission Record, dated 07/21/20, revealed R#1 was an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Significant Change MDS assessment, dated 05/06/20, revealed R#1: -had independent cognitive skills for decision making, -required extensive assistance from staff for dressing, toilet use, and personal hygiene, -required supervision for eating, -had no functional limitations in range of motion to upper or lower extremities, and -was at risk for developing pressure ulcers/injuries. Record review of R#1's Comprehensive Order Summary Report, dated 07/21/20, revealed R#1 had orders for, Stage IV sacral wound-cleanse with NS, pat dry, apply skin prep to peri wound. Apply Santyl, apply calcium alginate and cover with dressing daily and PRN, every shift. Start date, 06/16/20. Record review of R#1's, Weekly Pressure Ulcer Record, dated 06/22/20, revealed R#1 had a pressure ulcer to the sacrum that measured 1.4 cm in length, 0.5 cm in width and 0.5 cm in depth. Record review of R#1's care plans revealed no care plan that addressed R#1's Stage 4 pressure injury to the sacral area. Observation of R#1 on 07/21/20 at 11:40 a.m. revealed R#1 was in bed, with eyes closed. R#1 did not respond to surveyor's greeting. In an interview on 07/21/20 at 1:40 p.m., RN A said he was the Wound Treatment Nurse. RN A said R#1 had a Stage IV pressure injury to the sacrum. RN A said he provided wound treatment to R#1 as per physician's orders [REDACTED]. RN A said Administration was responsible to address the care plans that were needed to provide care, with goals and interventions. RN A said he did not know if a care plan for R#1's pressure injury had been developed. In an interview on 07/21/20 at 11:44 a.m., LVN B said R#1 had a pressure injury, Stage 4, to the sacrum. LVN B said care plans were developed to indicate the kind of care required to promote healing. In an interview on 07/21/20 at 9:58 a.m., ADON C said she was responsible for developing care plans for R#1. ADON C said she had not developed a care plan for R#1 since she was behind on reviewing physician orders, including the order from R#1's physician regarding R#1's Stage 4 to the sacrum. 2) Record review of R#2's Admission Record, dated 07/21/20, revealed R#2 was an [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's Baseline Care plan, dated 06/08/20, revealed R#2 had redness to pressure areas. Record review of R#2's Admission MDS assessment, dated 06/15/20, revealed R#2: -was in a persistent vegetative state, -was total dependent on staff for all ADLs, and -had a pressure ulcer, Stage 2. Record review of Nurse's Notes for R#2, dated 06/14/20, revealed R#2, with Stage 2 to coccyx redness to area, no drainage noted and no foul odor, 3.5 cm x 3.0 cm and redness to groin noted. Called MD, new orders given and carried out. Record review of R#2's care plans revealed no care plan that addressed R#2's Stage 2 pressure ulcer to the sacrum. Record review of R#2's Weekly Pressure Ulcer Record, dated 06/22/20, revealed R#2 had a pressure ulcer to the sacrum that measured 4.0 cm in length, 5.0 cm in width and 0.1 cm in depth. Record review of R#2's Comprehensive Order Summary Report, dated 06/08/20 to 07/31/20, revealed R#2 had orders for, Stage 3 pressure wound to sacrum - clean with normal saline, pat dry, apply skin prep to peri wound, apply Santyl, apply gauze and cover with dry dressing daily and PRN until healed, start date, 06/22/20. Record review of R#2's Comprehensive care plan, dated 06/22/20, revealed R#2 had a Stage 3 pressure wound to the sacral area. Interventions included: - provide wound care sacrum as ordered, - weekly skin assessments by licensed nurse, - turn and reposition every shift and as needed. In an interview on 07/17/20 at 12:16 p.m., ADON C said R#2 was admitted to the facility on [DATE] and a Stage 2 pressure injury had been identified on 06/14/20 by LVN B. ADON C said LVN B obtained treatment orders from R#2's Physician on 06/14/20. ADON C said no care plan for R#2's pressure injury was developed until 06/22/20, following the MDS assessment completed on 06/15/20. ADON C said no care plan to address R#2's Stage 2 pressure injury identified on 06/14/20 had been developed until 06/22/20, when the pressure injury was identified as a Stage 3. In an interview on 07/21/20 at 1:40 p.m., RN A said he was the Wound Treatment Nurse. RN A said R#2 had a Stage 3 pressure injury to the sacrum. RN A said he provided wound treatment to R#2 as per physician's orders [REDACTED].#2's Stage 2 pressure injury had been developed. Record review of R#2's Nurse's Notes, dated 07/06/20 at 8:25 p.m., revealed R#2 was found unresponsive. EMS was activated. At 8:55 p.m. EMS personnel notified staff at the facility that they had exhausted all efforts to revive the resident but were unsuccessful. At 9:55 p.m. R#2's Physician pronounced R#2's death. In an interview on 07/21/20 at 12:15 p.m., the DON said care plans had to be developed to address focus areas of concern, including pressure injuries. The DON said care had been provided to R#1 and R#2 for the pressure injuries, as ordered by their physician. In an interview on 07/21/20 at 12:15 p.m., the Administrator said care had been provided to R#1 and R#2, but care plans had not been developed as needed. Record review of the facility's undated policy titled, Care Plans-Baseline revealed: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS).

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