STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676195	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRACE CARE CENTER OF KATY	23553 WEST FERNHURST DRIVE KATY, TX 77494

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who entered the facility with pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development or worsen of pressure ulcers for 1 of 5 resident (Resident #1) reviewed for pressure ulcers. The facility did not provide adequate interventions to prevent Resident #1's left hip pressure ulcer from worsening The facility did not provide adequate interventions to prevent Resident #1's from developing three new pressure ulcers to his right hip, left upper back, and left lateral thigh within 6 weeks . The facility failed to document the development and assessment of Resident #1's pressure ulcer to right front hip for 6 days. These failures could affect facility residents who have pressure ulcers or are at risk of developing pressure ulcers by placing them at risk of developing new pressure ulcers and worsening of existing pressure ulcers. Findings included: Resident #1 Record review of the face sheet for Resident #1 revealed a [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's annual MDS dated [DATE] revealed a staff assessment of mental status indicating the resident had short term and long-term memory problems. Further review of the MDS revealed he was totally dependent on staff for care and had impairment to both sides of his upper and lower extremities. MDS revealed Resident #1 was at risk for pressure ulcers and had one unhealed pressure ulcer at a stage 4 that he was admitted with. The MDS reflected he received skin treatments of pressure reducing device for chair and bed, pressure ulcer care, and applications of ointments/medications. Record review of Resident #1's quarterly MDS dated [DATE] revealed same information as his annual assessment on 1/1/20. Record review of Resident #1's care plan updated 4/2/20 revealed he had a skin tear to left upper back area. Interventions included: provide progress notes to resident/family on healing, staff will be aware of fragile skin, assess wound healing weekly, provide treatment as ordered by physician, assess skin daily with routine care, full skin evaluation with bath/shower, assess changes in skin status that indicate worsening of pressure ulcer and notify the physician, perform skin care with attention to keeping skin folds clean and dry, reassess treatment plan if no healing within 2-4 weeks. Record review of Resident #1's care plan updated 4/17/20 revealed he had developed a pressure ulcer: unstageable with (slough and/or eschar) to left lateral hip. His interventions included: mechanical lift to avoid skin friction/shearing, repositioning: two persons assist, refer to wound specialist/wound clinic for evaluation, refer to dietician for evaluation of current nutritional status, start Pro-stat 30 cc via gastric tube twice a day for protein malnutrition. Provide progress report to resident/family on healing status, provide pressure reducing surfaces on bed and chair, provide supplemental nutritional support, labs: [MEDICATION NAME] level to evaluate protein, perform wound care, assess wound healing weekly, float heels off the bed, elbow protectors on both elbow, full skin evaluation with bath/shower, maintain head of bed angle at less than 30 degrees, administer pain medication. Record review of Resident #1's care plan updated 4/25/19 revealed he was had potential for alteration in skin integrity: Risk for skin tears/bruising/ breakdown due to: thin and fragile skin; dependent for bed mobility, repositioning and transfers, bowel and bladder incontinence; [MEDICAL CONDITION], impaired sensory perception due to severely impaired cognition, compromised nutrition; NPO with dependence for pe[DEVICE]. Interventions included: 1/25/19 left hip pressure ulcer - present upon admission. Administer skin care treatment and monitoring as ordered by physician wound care specialist referral and follow up as needed. Monitor for signs/symptoms of infection. Notify family with progress and treatment changes as needed. Frequent skin checks with routine care every shift and as needed. Complete skin assessment weekly and review or changes indicating possible skin care needs. Provide preventative skin care management during all shifts. Utilize pressure relieving devices as indicated. Assist resident with turning and repositioning, cluster task for check and changing for incontinence. Notify physician and responsible party as indicated for skin changes identified along with further skin care needs and interventions needed. Utilize wedge cushions and pillows for positioning, air loss mattress, assist resident with application of bilateral hand splints as tolerated. Record review of Resident #1's March/April 2020 Physician orders [REDACTED]. Tube Feeding - Order started on 4/21/20 - current to start [MEDICATION NAME] 1.5 at 50ml/hour x 20 hours. Supplement - Order started on 4/15/20 and discontinued on 4/21/20 for Prostat 30cc via peg tube twice a day for protein malnutrition. Supplement - Order started on 4/28/20 - for Prostat 30cc via peg tube twice a day for protein malnutrition. Record review of Resident #1's physician order [REDACTED]. Left Hip - Order started on 3/17/20 and discontinued 3/24/20 to cleanse left hip normal saline, pat dry, apply collagen powder, collagen patch, skin prep to edges and cover dry dressing daily. Left Hip - Order started on 3/24/20 and discontinued 4/1/20 to cleanse left hip with normal saline, pat dry, apply [MEDICATION NAME], collagen powder, and calcium alginate and cover with dry dressing daily Left Hip - Order started on 4/1/20 - current to cleanse left hip wound with normal saline, pat dry, apply collagen powder, collagen patch and cover with dry dressing daily. Left Upper Back/ Flank area Left Upper Back - Order started on 3/11/20 and discontinued 3/17/20 to cleanse left upper back with normal saline, pat dry, apply collagen patch and cover with dry dressing daily. Left Upper Back - Order started on 3/17/20 and discontinued 4/7/20 to cleanse left upper back with normal saline, pat dry, apply collagen patch, calcium alginate and cover with dry dressing daily. Left Upper Back - Order started on 4/7/20 and discontinued 4/28/20 to cleanse left upper back with normal saline, pat dry, apply [MEDICATION NAME], collagen powder, calcium alginate and cover with dry dressing daily. Left Flank area - Order started on 4/28/20 - current to cleanse wound to left flank area with normal saline, pat dry, apply collagen powder and collagen gel then cover with foam dressing daily. Left Lateral Hip Left Lateral hip - order started on 4/15/20 - current to cleanse left lateral hip with normal saline, pat dry, apply [MEDICATION NAME], collagen, calcium alginate and dry dressing daily. Right Hip-Re-opened wound Order started on 4/11/19 for Nyamyc 100,000 units/GM powder, wash area above right hip with soap and water pat dry apply [MEDICATION NAME] 2 times daily. Right Hip - Order started on 4/24/20 and discontinued on 4/28/20 to cleanse right hip with normal saline, pat dry, apply [MEDICATION NAME] and calcium alginate and dry dressing daily Right Hip - Order started on 4/28/20 - current to cleanse right hip with normal saline, pat dry, apply collagen then cover with dry dressing daily. Surveyors record review of Resident #1's electronic record on 4/28/20 at 9:30AM revealed no mention of right hip wound in his progress notes or wound assessments. Records review of Resident #1's wound healing progress/weekly wound assessment report revealed: Pressure ulcer left hip Measurements on date of wound discovery/development (1/25/19) - 3.50 x 3.00 x 1.00 (stage 4) Measurements on 3/3/20 - 1.60 x 1.70 x .10 (stage 4) Measurements on 3/11/20 - 1.70 x 1.70 x .10 (stage 4) Measurements on 3/17/20 - 1.80 x 1.90 x .10 (stage 4) Measurements on 3/24/20 - 2.00 x 2.10 x .10 (stage 4) Measurements on 3/31/20 - 2.90 x 2.80 x .10 (stage 4) Measurements on 4/7/20 - 2.60 x 2.50 x .10 (stage 4) Measurements on 4/15/20 - 2.50 x 2.40 x .10 (stage 4) Measurements on 4/22/20 - 2.40 x 2.30 x .10 (stage 4) Other: shear left upper back Measurements on date of wound discovery/development (3/11/20) - 2.10 x 1.40 (not staged) Measurements on 3/17/20 - 2.00 x 1.30 Measurements on 3/24/20 - 1.40 x .90 Measurements on 3/31/20 - 1.70 x 1.10 Measurements on 4/7/20 - 1.80 x 1.30 Measurements on 4/15/20 - 1.70 x 1.50 Measurements on 4/22/20 - 1.60 x 1.80 Pressure ulcer left lateral thigh - front Measurements on date of wound discovery/development (4/15/20) - 3.10 x 2.50 x 0.0 (unstageable due to slough/eschar) Measurements on 4/22/20 - 3.50 x 2.40 x .20 (unstageable due to slough/eschar) Further

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676195	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRACE CARE CENTER OF KATY	23553 WEST FERNHURST DRIVE KATY, TX 77494

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) review of Resident #1's wound assessments revealed no mention of any other current wounds (no wound to right hip). Record review of Resident #1's skin inspection reports revealed skin not intact - existing from 3/2/20 - 4/27/20. Interview with DON on 4/28/20 at 11:00AM revealed the skin inspection reports would not show if Resident #1 presented with a new wound. She said if he developed new skin concerns it would be captured on the wound assessments. Record review of Residents #1's progress notes dated 3/11/20 at 11:23AM revealed, Other//Left Upper Back .Wound doctor at bedside to assess wounds, shearing noted to left upper back with 100% granulated tissue with no drainage, new order to cleanse with normal saline, pat dry, apply collagen patch and cover with dry dressing daily. Wound to left hip unchanged with 10% slough and 90% granulated tissue with scant amount of serosanguineous (fluid composed of serum and blood) exudate. Current treatment continues. Air mattress in place. Voicemail left to family. Note was entered by wound care nurse. Record review of Resident #1's progress notes dated 3/17/20 at 12:45PM revealed, Pressure Ulcer//Left Hip// .Wound doctor at bedside to assess wounds, shearing to left upper back with 90% granulated tissue and 10% skin tissue with no drainage, current treatment continues. Wound to left hip unchanged with 100% granulated tissue with no drainage. New order for heavy collagen, collagen patch, skin prep to edges, and dry dressing. Air mattress in place. voicemail left to family. Note entered by wound care nurse. Record review of Resident #1's progress notes dated 3/24/20 at 12:22PM revealed, Pressure Ulcer//Left Hip// .Wound doctor at bedside to assess wounds, shearing to left upper back with 80% granulated tissue and 20% skin tissue with no drainage, current treatment continues. Wound to left hip with increased surface area with 80% granulated tissue and 20% slough with small amount of serosang exudate. New order for [MEDICATION NAME], calcium alginate, and collagen powder, and dry dressing. Air mattress in place. Family updated. Record review of Resident #1's progress notes dated 3/31/20 at 12:00PM revealed, Other//Left Upper Back// .Wound doctor at bedside to assess wounds, shearing to left upper back with 100% granulated tissue with scant amount of serosang exudate, current treatment continues. wound to left hip with increased surface area with 100% granulated tissue with small amount of serosang exudate. New order for collagen patch and collagen powder and dry dressing. Air mattress in place. Family updated. Note was entered by wound care nurse. Record review of Resident #1's progress notes dated 4/7/20 at 11:55AM revealed, Pressure Ulcer//Left Hip// .Wound doctor at bedside to assess wounds, shearing to left upper back with 50% granulated tissue and 50% slough with small amount of serosang exudate, current treatment continues. Wound to left hip improved with decreased surface area with 100% granulated tissue with scant amount of serosang exudate. Current treatment continues. Air mattress in place. voicemail left to family. Note was entered by wound care nurse. Record review of Resident #1's progress notes dated 4/15/20 at 2:31PM revealed, Pressure Ulcer//Left Lateral Thigh - Front// .Wound doctor at bedside to assess wounds, shearing to left upper back with 70% granulated tissue and 30% slough with small amount of serosang exudate, area debrided by wound doctor current treatment continues. Wound to left hip improved with decreased surface area with 100% granulated tissue with scant amount of serosang exudate, current treatment continues. Unstageable pressure ulcer noted with 20% slough, 60% eschar, and 20% granulated tissue with no drainage noted. New order to cleanse with normal saline, pat dry, apply [MEDICATION NAME], collagen powder, calcium alginate and dry dressing daily. Air mattress in place. Family updated. Record review of Resident #1's progress notes dated 4/22/20 at 1:46PM revealed, Pressure Ulcer//Left Hip// .Wound doctor at bedside to assess wounds, shearing to left upper back with 80% granulated tissue and 20% slough with small amount of serosang exudate, area debrided by wound doctor current treatment continues. Wound to left hip improved with decreased surface area with 100%granulated tissue with scant amount of serous exudate, current treatment continues. Unstageable pressure ulcer noted with 20% slough, 50% eschar, and 30% granulated tissue with small amount of serosang exudate. current treatment continues. Air mattress in place. Family updated. Note entered by wound care nurse. Record review of NP progress note for Resident #1 dated 4/22/20 revealed a chief complaint of new wound and an evaluation was required of wound healing and new wounds. Her review of skin revealed in part, .left hip wound, left flank shearing, left lateral hip wound, and right hip wound . left hip wound 2.4 x 2.3 x .1. 100% granulation. Scant serosanguineous drainage. Left flank shearing 1.6 x 1.8 x UTD (unable to determine). 20% slough, 80% granulation. Mild exudate. Debrided by wound care physician. Left lateral hip/thigh. 3.5 x 2.4 x UTD. 20% slough, 30% eschar, and 50% granulation. Right hip wound no measurements . Further review of the note revealed an assessment and plan noting, Right hip pressure ulcer - new problem - treatment nurse to evaluate and treat; consult wound care physician for new problem. Note indicated the plan of care was discussed with LVN #1, wound care nurse, and the DON. End of note revealed [DIAGNOSES REDACTED]. Record review of Resident #1's physician orders [REDACTED]. Record review of Resident #1's NP progress note dated 4/15/20 revealed in part, .Requested by nursing to evaluate the patient for new wound to left hip. Requesting protein supplements to be started for wound healing . protein calorie malnutrition, established problem - initiate protein supplement 30cc twice daily . Record review of Resident #1's progress noted dated 4/21/20 at 12:35PM revealed in part, .Monthly Nutrition Review - Wound/Tube feeding Re-Evaluation: Resident is [AGE] year-old male currently NPO. Tube feeding Order: [MEDICATION NAME] 1.5 @ 45 mL/hour x 20 . Resident has been gradually losing weight during the month. Weights for this month are as follows: 70.0, 68.6, and currently 66.0. Resident with improved existing wound with new additional wound recently identified . Resident has increased needs to promote weight gain and wound healing, therefore tube feeding rate was increased to meet those needs. Resident has noted weight loss during the month in addition to newly identified wound. Possible that resident needs are increasing due to progression of clinical conditions. Recommend increasing tube feeding to 50 mL/hour . Also recommend discontinuing liquid protein supplement as recommended tube feeding will provide 2.26grams protein/kilogram body weight. Will continue to monitor and will follow up as needed . Note was written by the Dietician. Interview on 4/28/20 at 9:45AM, Resident #1's RP said since 3/9/20 she had not been able to visit Resident #1 due to COVID restrictions. She said since then Resident #1 has developed two new wounds. The RP said she and other family members would visit the resident every day and make sure he was being cared for. She said she had concerns that since they are not able to come to the facility to see the resident, the facility may not have been as attentive to him as usual, causing him to develop new pressure ulcers. The RP said the resident has been having a wound to his left hip and now has an additional wound to his left hip area and another wound on his back. The RP said she did not know of any other wound development but wanted the matter looked into before he had further skin breakdown. She said the only rationale she was given for him now suddenly developing new wounds was because he was a complicated case given his malformations. Her main concern was that they were not repositioning the resident as they should and felt it was the only explanation why he would suddenly develop these new wounds now that families are not allowed in the building. She said she was notified of the development of the new wounds a week before 4/23/20. She said she requested to the see the wounds and was first told they could not send her pictures or video of the wound because of HIPAA. She said on 4/23/20 they finally allowed her to view the wounds via video call. She said she was shocked to see how large the wounds were and said they were very red. She said the residents old wound to his left hip looked like it had gotten worse. The RP said the family was very upset about him developing the wounds and was looking into moving the resident. Observation and interview on 4/28/20 at 10:05AM, Resident #1 was lying in bed unable to communicate. Resident had [MEDICAL CONDITION] attached. Residents body was noted to have deformities due to congenital disease. The upper body (chest and ribcage) were noted to be abnormally large compared to extremities. Also left upper chest and ribcage was larger than right chest/ribcage. Contractures were also noted to all four extremities. LVN #1 assisted surveyor with viewing Resident #1's wound areas. LVN #1 showed surveyor wound area to left mid upper back (ribcage area) that was covered with a dry dressing and the area to the residents left hip that was also covered by a dry dressing. LVN #1 was asked about the development of Resident #1's pressure ulcers and she stated, the pressure ulcer to the left hip was not new for it had re-opened in the last 4-6 weeks but the pressure ulcer to the mid-upper back was new. LVN #1 also stated there was two pressure ulcers to the left hip area covered by the one dressing and one of the pressure ulcers to the left hip was also new. Observation and interview on 4/28/20 at 10:12AM, LVN #1 was asked if Resident #1 had any other pressure ulcers in addition to the ones already observed in the left hip and left mid-upper back areas. LVN #1 said he had another pressure ulcer to the right hip area that had recently developed. LVN #1 then was asked to assist with the observation of the pressure ulcer to the right hip area. Observation revealed an ulcer to the right hip/close to the right inguinal area covered by small dry dressing. While assisting with the observation, LVN #1 said she was placing small area of resident's gown between right lower abdominal area and right inner hip/inguinal area to help relieve the pressure to that area. She also stated that she and other staff were using pillows to relieve pressure areas on Resident #1's body. Interview on 4/28/20 at 10:30PM, wound care physician said Resident #1 had developed new wounds within the last 6 - 8 weeks and his left hip wound that they had down to almost healed had also began to slowly reopen. The wound care physician said he was not sure why the resident was now developing these new pressure ulcers. He said the resident was very high risk for developing pressure ulcers given his severe deformities and said the resident was also nutritionally compromised. The wound care physician said today was his first day viewing the wound to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676195	A. BUILDING _____ B. WING _____	**04/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRACE CARE CENTER OF KATY	**23553 WEST FERNHURST DRIVE KATY, TX 77494**

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) right hip and said the resident had previously had a wound to that area that had healed up a while ago. He could not recall how long ago the resident had the wound to right hip but said it had been healed for a long time. The physician suggested a reason for wound developing and not healing could be due to [MEDICAL CONDITION] with the resident not able to see his family who would visit him daily. He said the resident cannot communicate but he had noticed a change in the residents affect and said it was flat and the resident was not responding like he usually would. The physician said he was going to order some labs for the resident to see if there was something going on. Record review and interview on 4/28/20 at 11:00AM, the DON said Resident #1 had recently developed wound to his right hip within the past week and she was not sure of the exact date when it developed. She was asked where it would be documented because surveyor only saw mention of the wound in the physician orders [REDACTED]. The DON said the information should be in the wound assessments. The DON looked through the electronic record with surveyor where it was viewed there was no mention of the right hip wound under the wound assessments. The DON then instructed the surveyor to look under the progress notes and to click on the tab to view wound assessments. The last wound assessment note that appeared on screen was from 4/22/20 that did not have mention of the right hip wound. The DON said she would check with the wound care nurse of where her documentation was for the wound on the right hip and clarify when it was discovered. The DON said Resident #1 was at risk for developing pressure ulcers because of his severe deformities. She said the facility did have preventative interventions in place for him not to develop pressure ulcers since his admission. She said the resident has always had an air mattress and they would do frequent repositioning every 2 hours and as needed. She said the staff would make sure the resident stayed cleaned by providing incontinent care, baths, apply moisture barrier creams, and completing weekly skin assessments. She said the resident also saw a wound care specialist weekly for the care of his wounds and received daily wound care from the facility for his existing wound. The DON said the resident had a special formula for his [DEVICE] that he's always had to provide him with enough protein. The DON was asked after Resident #1 developed his first new pressure ulcer to left upper back on 3/17/20, were there any new or changed interventions to further prevent the development of pressure ulcers and she said they adjusted the way they were positioning the resident by using more pillows and rolled up towels versus the positioning wedge. She said as the resident continued to develop the two additional pressure ulcers they continued to try and change the way they were positioning the resident to relieve pressure off wounds but said it was very difficult to do without putting pressure on other pressure points on his body because of his deformities. The DON added the resident did have a specialized wheel chair, but the resident was not put into it lately because family only wanted him up in the wheel chair with them present. Family had been restricted from visiting due to COVID precautions since March. There were no other interventions mentioned specific to the resident deformities aside from repositioning. Interview and record review on 4/28/20 at 3:00PM, the DON was asked if she got clarification from the wound care nurse on when Resident #1's right hip wound was discovered and where the documentation was for it. The DON replied that the notes for the right hip wound was given to the surveyor with the copies of the residents record that were requested (records were brought to surveyor around 2:00PM). The paper records were reviewed with the DON and revealed a progress note dated 4/24/20 at 1:39PM that was entered by the wound care nurse. The note revealed, recurring ulcer noted to right hip with 100% granulation tissue and no drainage. New order to cleanse with normal saline, pat dry, apply [MEDICATION NAME] and calcium alginate and cover with dry dressing. Family notified, and NP notified. The DON was asked where the note was in the electronic record and she explained it was in the progress notes. The DON was reminded the progress notes were reviewed with the surveyor and there was not a wound assessment note on 4/24/20 that came up. The electronic record was reviewed again with DON and the note referenced above for 4/24/20 was then showing in the record. The DON said she did not recall reviewing the progress notes in the electronic record with the surveyor and said she only recalled looking through the weekly wound assessments. Surveyor requested to speak with the wound care nurse to discuss when the note from 4/24/20 was entered. Interview on 4/28/20 at 3:56PM, CNA #1 and CNA #2 said they both cared for Resident #1. They said the resident was always in bed and needed two people assist with everything. They said they were aware of Resident #1's wounds and the interventions they would use was to reposition him every 2 hours and as needed. They said they would try and keep him turned on his right side to keep him off his wounds on the left side. They said since the resident developed wound to his back they stopped using the positioning wedge and just used pillows to position him in bed. They said the ADON gives them instructions on how to care for Resident #1 and how they should position him in bed. The CNA's denied discovering Resident #1's new wounds and said the bandages were already there when they would come in to care for him. They said if they were to notice and new skin concerns they would notify the nurse. Interview and record review on 4/28/20 at 4:15PM, the DON said the wound care nurse had already left for the day. The wound care nurse phone number was requested. The DON was shown the NP progress note dated 4/22/20 reviewed above that indicated the right hip wound was discovered on 4/22/20 and not 4/24/20 as indicated by the wound care nurse progress report. The DON said the NP note read as if the NP had discovered the wound. She said the staff would have only been aware of the wound if the NP would have notified them and said the staff were not aware of the wound on 4/22/20. The DON said the NP's usually visit residents and assess them on their own and the facility staff are usually not present. The DON was shown the portion of the note that indicated the plan of care was discussed with herself, the wound care nurse, and LVN #1. The DON said she saw that's what the note said but denied being told about the right hip wound on 4/22/20 and suggested the NP may have forgot to mention the right hip wound to staff. The NP phone number was also requested from the DON. Interview on 4/28/20 at 4:20, the ADON said Resident had developed his last wound to the right hip sometime last week and said she thought the wound care nurse was the one who discovered the right hip wound. The ADON said the interventions they were using for to prevent and treat Resident #1's wounds were by frequent repositioning, offloading him, making sure nothings touching and they were doing so with the use of pillows. The ADON was asked her opinion on why Resident #1 had developed his new wounds and she suggested temperature change with it being warmer outside. She said they decreased the number of pillows being used so the resident would not get hot and sweaty and provided a fan in his room. She said the family liked to position the resident a certain way, but they had to explain to the family they could not use all those pillows because it could affect the effectiveness of his air mattress. She said the fan was just put into his room the past weekend (2-3 days ago). She said they had been using a positioning wedge in the past but stopped the use of the positioning wedge when he began developing new wounds. The ADON spoke about the difficulties of positioning the resident and offloading with the deformities he had. Observation on 4/28/20 at 4:30PM, Resident #1 pressure ulcers were as follows: pressure ulcer (approximately 1-2 cm in circumference, stage 2) to left mid- upper back (ribcage area), two pressure ulcers to left hip area (both ulcers adjacent to each other and with approximately 2-3 cm in circumference each), one pressure ulcer to the right hip/close to the right inguinal area (approximately 2 cm in diameter, possible stage 2 due to broken skin). Observation was made with ADON. Phone interview attempted on 4/28/20 at 4:54PM with the wound care nurse, there was no answer. A voicemail was left with no return phone call. Phone interview on 4/28/20 at 5:16PM, the NP said she had identified the wound to Resident #1's right hip during her visit with him on 4/22/20. She said she usually doesn't look at his wounds because he had a wound care doctor but given the concerns of him developing new wounds she wanted to assess them. She said her and a nurse from the facility were looking over the resident wounds when they noticed that he had also developed a wound to his right hip. She said the facility was made aware of the right hip wound that was discovered during her visit. She could not recall who the nurse was who was in the room with her. Record review of the facility's Pressure Ulcer/Skin Breakdown - Clinical protocol policy (revised April 2018) revealed in part, .1. the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcers. 2. In addition, the nurse shall describe and document/report the following: a. full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissues; b. pain assessment; c. residents mobility status; d. current treatments, including support surfaces; and e. all active [DIAGNOSES REDACTED]. 2. The physician will clarify the status of relevant medical issues . 1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. 2. The Physician will help identify medical interventions related to wound management . 3. The physician will help staff characterize the likelihood of wound healing based on a review of pertinent factors . 4. As needed the physician will help identify medical and ethical issues influencing wound healing . Further review of the policy revealed in part, . 1. During the resident visit, the physician will evaluate and document the progress of wound healing - especially for those with complicated, extensive, or poorly - healing wounds. 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wound develop despite existing interventions. A. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. B. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676195	A. BUILDING _____ B. WING _____	**04/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRACE CARE CENTER OF KATY	**23553 WEST FERNHURST DRIVE KATY, TX 77494**

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) medical conditions MAR indicated [REDACTED].