STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676332	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MEDICAL RESORT AT BAY AREA	4900 EAST SAM HOUSTON PARKWAY SOUTH PASADENA, TX 77505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and, record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodations of resident needs for 1 of 9 residents (Resident #3) reviewed for reasonable accommodations in that; The facility failed to ensure Resident #3 received assistance in a timely manner when she pressed the call light. This failure could affect residents who need assistance and place them at risk for decreased quality of life. Findings include: Record review of Resident #3's face sheet revealed, a [AGE] year-old female originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's 48-hour Baseline Care plan dated 6/20/20 revealed, Assistance checked in the ADL Function Does the resident require assistance with: Bed mobility, Ambulating, Dressing, Personal hygiene, Eating, Toilet Use? Further record review of Resident #3's 48-hour Baseline Care plan revealed, in the Mobility 8. Does the resident use an assistive device such as a cane, walker or wheelchair for ambulation or locomotion? Yes was checked. Record review of Resident #3's physician orders [REDACTED]. Record review of Resident #3's physician orders [REDACTED]. safety awareness training, balance training, therapeutic activity and wc mobility to improve functional mobility and to decrease risk for falls . Interview and observation on 6/24/20 at 10:46am with Resident #3, the resident's call light was on prior to the surveyor entering her room. The resident was sitting on the edge of her bed, she had a dressing on her left foot and a PICC line to her right upper arm. She said her call light has been on for at least 20 minutes stating it takes a while to get help. When asked if she has had problems with staff answering the call light in a timely manner, she stated, Yes, further stating she had to wait hours for someone to assist her in the shower. She said she needs assistance with showers because her PICC line and dressing on her foot need covered with plastic and she is unable to shower by herself. She again stated she will press the call light and the staff will take their time answering it. Observation on 6/24/20 at 10:50am of the Administrator, he walked past the resident's room and did not answer Resident #3's call light. Observation on 6/24/20 at 10:53am, observed two staff walking past Resident #3's room without answering the call light. Observation and interview on 6/24/20 at 10:56am, Resident #3 was sitting in a wheelchair next to the dresser with a water flavor packet in her hand. When asked if anyone answered her call light, she stated no, further stating she got out of bed herself, moved to her wheelchair and got the flavor packet for her water. She stated she was tired of waiting and wanted her water. Observation and interview on 6/24/20 at 10:58am of CNA A, the CNA was observed going into Resident #3's room. When the surveyor informed the CNA that Resident #3's call light had been on for over 10 minutes, she said she had the 300-hall plus the 400-hall stating she was normally on the other side. Interview on 6/24/20 at 12:22 pm with the Administrator, when asked about call lights, he stated there were two CNAs assigned to a hall unless someone calls in. He further stated they are trying to beef up staffing. When informed three residents waited over 10 minutes to have their call lights answered, and multiple staff were observed walking past residents rooms when the light was on, he stated it is unacceptable to have a call light on greater than 10 minutes, further stating the call lights can only be heard at the nurses station and the staff may not see the light is on because of the position of the light requiring them to look up. Record review of the facility's Grievance log dated 3/19/20 read in part, Resident say it is taking a while for call light to be answered. Record review of the facility's Grievance log dated 6/9/20 read in part, .(family member) states at times call light not answered promptly. Record review of the facility's Answering the Call light policy revised October 2010 read in part, .General Guidelines .8. Answer the resident's call as soon as possible.
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide and document adequate preparation to residents to ensure safe and orderly transfer or discharge from the facility for 1 of 6 residents (CR #1) reviewed for transfer/discharge in that; The facility failed to properly document CR #1's transfer to the hospital. This failure could affect discharged residents and placed them at risk of an unsafe discharge/transfer. Findings include: Record review of CR #1's face sheet revealed, a [AGE] year-old-female admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of CR#1's physician orders [REDACTED]. Record review of CR #1's nursing progress notes dated 6/19/20 at 03:18 am read in part, Client refused attempt to start PIV. Further record review of nursing progress notes dated 6/19/20 at 05:48am read in part, eMAR-Orders Administration note. There was no documentation stating orders were given to transfer the resident to the hospital, the residents RP was notified of the transfer, or the resident was transferred safely to the receiving hospital. Telephone interview on 6/24/20 at 8:45 am with CR #1's family member, he stated the resident was transferred to the hospital on [DATE] and no one was aware or notified of the transfer. He stated his other family member would go up to the facility almost daily to bring the resident Gatorade and on Saturday, 6/20/20, was when the family found out about the transfer. Interview on 6/24/20 at 11:46am with the DON, when asked the date CR #1 was transferred to the hospital, she stated the resident was transferred on 6/19/20. When asked what the policy was regarding who was notified about the transfer and when, she stated once the MD places the order for the resident to be transferred, the RP would be notified about the transfer stating the RP would be informed where the resident was transferred and the reason for the transfer. When asked what the policy regarding documentation of a resident transfer is, she stated the transfer details would be documented in the nursing progress notes in PCC. When informed there was no documentation of transfer orders, a SBAR and/or transfer summary, or progress notes indicating the resident was transferred to the hospital or the RP was notified, she stated she would have to ask the discharge nurse where she documented the residents' transfer. Further interview on 6/24/20 at 11:46am with the DON, when asked if the residents RP was notified about her COC and transfer, she stated she was standing next to LVN #1 who contacted the residents RP. She said she knew she contacted him but was unable to reach the RP. When asked if this would be documented in the progress notes, she stated it should be, she said she did mention to LVN #1 she needed to document the transfer in the progress notes. Telephone interview on 6/24/20 at 1:38pm with LVN #1, when asked about CR #1's discharge, she stated she was new to the facility, further stating she contacted CR#1's RP by phone to notify him of the residents COC and transfer to the hospital. She stated she did not speak to him but made multiple attempts to call stating she called four times. She said he never answered the phone, so she left a VM stating she needed him to call back to discuss the residents care plan and left the facility's phone number. She stated she did not mention the resident's COC or transfer because she did not want to alarm the RP. When asked what the policy was regarding the completion of discharge/transfer summary and documentation of a transfer, she stated an interact transfer form is completed in PCC, further stating she thinks she completed but wasn't sure if she signed it. She stated she may have exited without signing the document. Record review of CR #1's eInteract Transfer Form V4.0 Discharge to hospital revealed it was showing In Progress with a date of 6/19/20, and was not completed. Interview on 6/24/20 at 2:55pm with the DON, when again asked who was responsible for ensuring the eInteract Transfer form for discharge/transfer was completed, she stated sometimes the nurses complete the paperwork, but the D/C coordinator was responsible. When asked when the form should be completed, she stated upon discharge/transfer. When she was shown the eInteract Transfer Form that was In Progress she could not state why

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

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

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F 0624 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) it was not completed. Interview on 6/24/20 at 3:15pm with the Discharge Coordinator, when asked who was responsible for completing the discharge/transfer form, she stated the nurses were responsible for completing the form. When asked when the form should be completed, she stated it should be completed upon discharge. Record review of the facility's Transfer, or Discharge, Emergency policy revised April 2013 read in part, .Emergency Transfer or Discharge Procedures .a. Notify the resident's Attending Physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident; e. Notify the representative (sponsor) or other family member .
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and, record review, the facility failed to provide the necessary services to maintain grooming and personal care for 2 of 10 residents (Resident #2 and Resident #4) reviewed for ADL care in that; Resident #2 and Resident #4 were not provided timely incontinent care by facility staff. This failure could affect residents who require ADL assistance and placed them at risk of possible skin breakdown and a decreased quality of life. Findings include: Resident #2 Record review of Resident #2's face sheet revealed, a [AGE] year-old-male originally admitted on [DATE] then re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's 48-hour baseline care plan dated 6/20/20 revealed, documentation in the ADL Function section showing the resident requires assistance with transferring, toilet use, and personal hygiene. Further record review of the 48-hour care plan revealed, in the Bladder Function section, No checked for, Is the resident continent of bladder? and No checked for Is the resident continent of bowel? Observation on 6/24/20 at 10:50 am of Resident #2 revealed the resident's call light was on from 10:50am-11:00am. Three staff were observed walking past the residents' room without answering the call light. Observation on 6/24/20 at 11:00 am, Housekeeping #1 entered Resident #2's room, turned off the call light and asked what the resident needed. She then told CNA A the resident needed help. Observation on 6/24/20 at 11:01 am of CNA A, she entered the residents room to address assist him to the restroom. Interview on 6/24/20 at 11:03am with Housekeeping #1, when asked if she was answering call lights often, she stated if she saw a call light on she would try to help if she could, but if it was something she could not do, she would get help. Interview and observation on 6/24/20 at 11:11 am with Resident #2, he was observed lying in bed awake and watching tv. The resident was alert and oriented to person and place. When asked why he pressed the call light, he stated he needed help to get out of bed to use the restroom. When asked if he has had a problem with staff answering his call light in a timely manner, he stated, yes, further stating he has only been at the facility several days. He stated a few days ago he tried to get up from his bed to use the restroom because no one came to help, and he fell . He said he had no injuries further stating, after the fall he was told to ask for help before getting up from his bed. Record review of Resident #2's nursing progress notes dated 6/21/20 read in part, Resident had restroom call light on, CNA went into the room and resident was sitting at the edge of the toilet squatting almost on the floor resident assisted to the floor and then placed back in his W/C X3 staff members. CNA called writer into room writer asked resident what happened, and resident stated well I know I'm not supposed to transfer myself but I just don't like having to depend on others writer reminded resident that we are here for his safety. Resident then stated ok, I won't be trying to transfer myself anymore, I guess I'll just have to go back to relying on others to do everything for me . Resident #4 Record review of Resident #4's face sheet revealed, a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's Admission MDS dated [DATE] revealed, a BIMS score of 15 indicating an intact cognition. Record review of Resident #4's Care plan read in part, Focus: Resident #4 has an ADL self-care performance deficit r/t muscle weakness, limited mobility. Goal: The resident will improve current level of function in (ADLs) through the review date. Interventions/Tasks; .PERSONAL HYGIENE: the resident requires (assistance) by staff with personal hygiene and oral care. TRANSFER: The resident requires Mechanical Lift with (2) staff assistance or transfers .Encourage the resident to use bell to call for assistance . Further record review of Resident #4's Care plan read in part, Focus: Resident #4 is (Moderate) risk for falls r/t Deconditioning Interventions/Tasks: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Observation on 6/24/20 at 11:26 am of Resident #4 revealed, the residents call light was on from 11:26am to 11:41am when the surveyor intervened and informed CNA B the resident needed to be changed. Observation and Interview on 6/24/20 at 11:37 am of Resident #4, the resident was lying in bed awake, alert, using her tablet. She was on continuous O2 via NC at 4 LPM. When asked why she pressed the call light, she stated she needed her brief changed. When asked if she has had problems with staff answering the call light in a timely manner, she stated, yes further stating she has had to wait up to an hour for someone to help her. She stated she has lied in bed dirty waiting for the staff to assist, stating they never come when you press the call button. Interview on 6/24/20 at 11:41 am with CNA B, when informed Resident #4's call light had been on for over 10 minutes and no one had entered her room to ask what she needed, she stated she was doing a bed bath. When asked if there was an issue with answering call lights timely, she said it was only her 2nd day working at the facility, but she will often be pulled from one room to another to assist with residents. She stated there were two CNAs assigned to her hall for 19 residents. Observation on 6/24/20 at 11:43 am of CNA B and CNA C, the CNAs entered Resident #4's room to complete ADL care. Interview on 6/24/20 at 12:22 pm with the Administrator, when asked if there was an issue with timely response of call lights, he stated there were two CNAs assigned to a hall unless someone calls in. He further stated they were trying to beef up staffing. When informed three residents waited over 10 minutes to have their call lights answered, and multiple staff were observed walking past residents rooms when the light was on, he stated it was unacceptable to have a call light on greater than 10 minutes, further stating the call lights can only be heard at the nurses station and the staff may not see the light is on because of the position of the light requiring them to look up. Record review of the facility's Answering the Call Light policy revised October 2010 read in part, General Guidelines .8. Answer the resident's call as soon as possible .
F 0694 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure parental care and services were administered consistent with professional standards of practice for 1 of 1 resident (Resident #3) reviewed for intravenous fluid. Resident #3's PICC line dressing was visibly soiled and had not been changed. This failure could affect residents with IVs and placed them at risk of not receiving the appropriate IV care and possible infection and a decline in health. Findings include: Record review of Resident #3's face sheet revealed, a [AGE] year-old female originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's 48-hour Baseline Care plan dated 6/20/20 revealed, No documented for cognitive impairment and IV medications checked in the Specialized Services and Treatments section. Record review of Resident #3's physician order [REDACTED]. Interview and observation on 6/24/20 at 10:46 am with Resident #3, the resident was sitting on the side of her bed. She had a PICC line to her right upper arm. The dressing was soiled with a light pink tinge on the gauze and the clear [MEDICATION NAME] covering was rolled up on the sides and not fully secured. There was no date or initials on the dressing to indicate when the dressing was changed. When asked how long she had the PICC line and when it was last changed, the resident stated she had the PICC line since last Wednesday, 6/17/20. She said they have not changed the dressing since she was readmitted to the facility. She further stated the dressing need to be changed because it was dirty and falling off. Interview on 6/24/20 at 11:08 am with LVN #2, when asked when PICC line dressings should be changed, she stated she was pretty new to the facility stating it was her fifth day working. She further stated she thought the dressing should be changed weekly. When asked if the dressing should be labeled, she stated the dressing should have the date changed and the nurses' initials. Interview and observation on 6/24/20 at 11:10 am with LVN #2 and Resident #3, when asked about Resident #3's dressing, LVN #2 stated it needed to be changed. When asked if she could find any date or initials on the dressing, she could not find any labeling. She stated she would change the residents dressing now. Interview on 6/24/20 at 11:46am with the DON, when asked what the policy was regarding PICC line dressing changes and how often the dressing should be changed, she stated she thinks every 72 hours, further stating if a resident was admitted to the facility with an IV, or Midline, the dressing must be changed upon admission. She stated she was not sure what the exact policy was, stating she would have to look it up. Record review of the facility's Midline/PICC Dressing Changes policy revised December 2012 read in part, Purpose: The purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened, or soiled catheter-site

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F 0694 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) dressings. General Guidelines 1. Change midline catheter dressing 24 hours after insertion, every 7 days, or if it is wet, dirty, not intact, or compromised in any way .Steps in the Procedure: Procedure to apply sterile dressing: 6. Apply the sterile transparent dressing or gauze with transparent dressing to area, making sure to center the dressing over the insertion site .Label with initials, date and time.