STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676274	A. BUILDING _____ B. WING _____	**08/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REMARKABLE HEALTHCARE OF SEGUIN	**1339 EASTWOOD DR SEGUIN, TX 78155**

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 of 6 Residents (Resident #1) reviewed for care plans in that: Resident #1 did not have a baseline care plan in place. This deficient practice could place newly admitted residents at risk of care or services not being provided as needed. The findings were: Record review of Resident #1's Admission MDS (Minimum Data Set) Assessment, with entry date of 8/10/20, revealed Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's EMR (Electronic Medical Record) revealed Resident #1 did not have a baseline care plan under the Assessment tab, in nursing notes, or under the Care Plan tab. During an interview on 8/31/20 at 12:13 pm, the DON stated Resident #1 should have had a baseline care plan completed within 24 hours of admission and it should have been under the Assessment tab in Resident #1's EMR. The DON stated she, the MDS Coordinator and the ADONs were working night shifts and over the weekends to cover nurses who called out, and she could not expect the MDS Coordinator to work constantly. The MDS Coordinator had not had enough time to complete resident care plans. The DON stated she planned to hire another MDS Coordinator who could dedicate herself to care plans only. When the DON was asked if she had enough staff to care for the residents and cover all facility responsibilities she stated she had no choice the last few months because the floor had to be covered due to call-ins.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interview and record review, the facility failed to develop and implement a person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 6 residents (Resident #2) reviewed for comprehensive care plans in that: Resident #2 had only 2 items listed on her most current care plan which did not cover all the focus care areas Resident #2 required. This deficient practice could affect residents who had comprehensive care plans and could result in inaccurate information for required care. The findings were: Record review of Resident #2's Order Summary Report, dated 8/28/20 with active orders as of 8/28/20, revealed Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #2's Care Plan Overview in Resident #2's EMR revealed one care plan was completed with date initiated on 2/6/20. Record review of Resident #2's Care Plan, initiated on 2/6/20, revealed two focus areas including, Resident #2 is dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits, disease process ([MEDICAL CONDITION]), and physical limitations and Resident #2 is on a regular diet. Futher review revealed no other focus areas. During an interview on 8/28/20 at 3:40 pm, the MDS Coordinator confirmed she worked at the facility as the MDS Coordinator for a little over a year. The MDS Coordinator stated Resident #2 was admitted on [DATE] and Resident #2's care plan dated 2/6/20 was her admitting care plan, and the care plan should have included all areas of care that Resident #2 needed. The MDS Coordinator stated she was responsible for the nursing focus areas of the care plans and she had overlooked Resident #2's care plan. Record review of a facility policy titled, Care Plans - Comprehensive, revised April 2010, revealed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and revised and interviews the facility failed to develop and revise comprehensive care plans after each assessment, including both the comprehensive and quarterly review assessments, for 2 of 6 residents reviewed (Resident #2 and #3). 1. Resident #2 did not have quarterly care plans completed. 2. Resident #3 did not have quarterly care plans completed. This deficient practice could affect all residents by placing them at risk of not receiving the proper care to meet their needs. The findings were: 1. Record review of Resident #2's Order Summary Report, dated 8/28/20 with active orders as of 8/28/20, revealed Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #2's Care Plan List Overview in Resident #2's EMR under the Care Plan tab revealed one care plan was completed with date initiated on 2/6/20. Record review of Resident #2's Care Plan, initiated on 2/6/20, revealed two focus areas including, Resident #2 is dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits, disease process ([MEDICAL CONDITION]), and physical limitations and Resident #2 is on a regular diet. No futher revisions. 2. Record review of Resident #3's Order Summary Report, dated 8/28/20 with active orders as of 5/16/20, revealed Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record Review of Resident #3's Care Plan List Overview in Resident #3's EMR under the Care Plan tab revealed one care plan was completed with date initiated on 2/13/20. During an interview on 8/28/20 at 3:40 pm, the MDS Coordinator stated she worked at the facility as the MDS Coordinator for a little over a year. The MDS Coordinator stated Resident #2 was admitted on [DATE] and Resident #2's care plan dated 2/6/20 was her admitting care plan, however, Resident #2 should have had two additional quarterly care plans completed. The MDS Coordinator stated she was responsible for the nursing focus areas of the care plans and making sure quarterly care plans were initiated and updated. The MDS Coordinator stated Resident #3 had one care plan completed and should have had one more quarterly care plan completed. During an interview on 8/31/20 at 12:13 pm, the DON stated Resident #2 should have had 1 to 2 quarterly care plans in place and in the EMR. The DON acknowledged there is only one care plan from 2/6/20 for Resident #2 completed and documented in the EMR. The DON stated Resident #3 only has one care plan from 2/13/20 and should have had 1 to 2 quarterly care plans completed and documented in the EMR. The DON stated the MDS Coordinator was responsible for MDS and care planning. The DON stated she, the MDS Coordinator and the ADONs were working night shifts and over the weekends to cover nurses who called out, and she could not expect the MDS Coordinator to work constantly. The DON stated the MDS Coordinator had not had enough time to complete resident care plans. The DON stated she planned to hire another MDS Coordinator that could dedicate herself to care plans only. When the DON was asked if she had enough staff to care for the residents and cover all facility responsibilities she stated she had no choice the last few months because the floor had to

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

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) be covered due to call-ins. Record review of a facility policy titled, Care Plans - Comprehensive, revised April 2010, revealed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans at least quarterly.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed in accordance with accepted professional standards and practices to maintain medical records on each resident that are accurately documented the wound assessments for 1 of 6 Residents (Residents #3) reviewed for records in that: 1. Resident #3's medical record did not include documentation of weekly skin assessments on a consistent basis from the unit assigned nurse. 2. Resident #3's medical record, during the resident's wound history, did not include documentation of weekly skin assessments on a consistent basis by the wound care nurse. This deficient practice could affect Residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. Findings included: 1. Record review of Resident #3's Order Summary Report, dated [DATE] with active orders as of [DATE], revealed Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's EMR revealed a Braden Scale assessment completed on [DATE], the day after her admission, which indicated Resident #3 was at a very high risk for skin issues related to potentially inadequate dietary intake, bedfast, decreased mobility, etc. Record review of available Resident #3's EMR revealed a list of Weekly Wound Assessments were completed and documented for the following dates: (missing week: [DATE]), [DATE],(missing weeks:2 /,[DATE], and [DATE]), [DATE], (missing week:[DATE]), [DATE],(missing week: [DATE]), [DATE], [DATE], [DATE], [DATE], [DATE],(missing week:[DATE]),[DATE], and (missing weeks:[DATE] and [DATE]). Record review of Resident #3's Weekly Wound Assessment Completed on [DATE] revealed Resident #3 had a surgical incision to right [MEDICAL CONDITION] 17 centimeters X 0.5 centimeters stitches intact and left buttock appeared with moisture associated [MEDICAL CONDITION] measuring 1.2X0.4 centimeters. Record review of Resident #3's Weekly Wound Assessment, dated [DATE], revealed Resident #3 had a healed surgical incision to RLE w/q d (Right Lower Extremity with daily) treatment in place, L (Left) buttock MAD w/q (with daily) shift treatment in place; both areas followed wkly. by wound care. Record review of Resident #3's Weekly Wound Assessment, dated [DATE], revealed Resident #3 had a healed surgical incision to RLE w/q d)Right Lower Extremity with daily) tx (treatment) in place, L buttock MAD w/q (with daily) shift tx in place; both areas resolving. Record review of Resident #3's Weekly Wound Assessment, dated [DATE], revealed Resident #3 had redness to buttocks, treatment in place. Record review of Weekly Skin assessment dated [DATE] revealed Resident #3 had a surgical incision site BKA from previous stay. In Healing stage and a new Stage II Pressure measurement 2.3X2.5X0.1 cm. Treatment in Point-Click-Care. During an interview on [DATE] at 12:20 PM, with LVN A, who worked on the LTC (Long Term Care) side for units 500, 600, 701 for 4.5 years, stated the Weekly Skin Assessments are completed every week by the nurses and documented in the EMR. 2. Record review of Resident #3's EMR revealed a list of Wound Nurse Weekly Skin Assessments were completed and documented for the following dates: [DATE], [DATE], and [DATE]. During an interview on [DATE] at 2:15 pm, the Wound Care Nurse stated she worked at the facility since [DATE] and the nurses told her verbally or on the dashboard in the EMR messaging platform if a resident has a wound or skin issues. The wound assessments were done weekly by the Wound Care Nurse and the Weekly Wound Assessments should be done weekly by the nurses and documented in the resident EMR. The Wound Care Nurse stated Resident #3's amputation wound healed well, however, Resident #3 started to go downhill because Resident #3 stopped eating so they sent her out to the hospital. The Wound Care Nurse stated Resident #3 got moisture associated [MEDICAL CONDITION] (MAD). The Wound Care Nurse had the wound care doctor see Resident #3 when she started to go downhill. The Wound Care Nurse stated she first assessed Resident #3 on [DATE] due to Resident #3's MAD to the left buttock and her amputation stump but did not assess her again until [DATE] due to a pressure ulcer to Resident #3's right buttock. The Wound Care Nurse stated she assessed Resident #3 again on [DATE] for a left heel, left great toe, left foot lateral, and left buttock pressure ulcer. The Wound Care Nurse stated she placed Resident #3 in boots and applied skin prep. The Wound Care Nurse stated she usually visits residents with pressure ulcers for assessment with doctor via telehealth, cleaned, and measured the wound areas once per week. The Wound Care Nurse stated the treatment for [REDACTED]. She assessed Resident #3 on [DATE], but the assessment was not in PCC and instead documented in her wound binder. She assessed Resident #3 four times on [DATE], [DATE], [DATE] (not documented in PCC), and [DATE]. She did not assess Resident #3 between [DATE] and [DATE] because she was either in [MEDICAL TREATMENT] or in the hospital. The Wound Care Nurse stated she could have seen her later in the day or the next day in the case of her being out of the facility for [MEDICAL TREATMENT]. During an interview on [DATE] at 4:18 pm, the DON stated Resident #3 was admitted on [DATE] but discharged to the hospital on [DATE] and returned on [DATE], discharged [DATE] and returned on [DATE], discharged [DATE] and returned on [DATE], discharged on ,[DATE] and returned [DATE], and on [DATE] Resident #3 was gone for the day, and expired [DATE]. The DON stated the LVN/RN was responsible for performing a skin assessment once a week for all residents, and if they are followed by wound care then the resident should have a weekly skin assessment performed by the nurses and wound assessment from the wound care nurse for every week. The DON stated she did not know why the skin assessments were not completed and documented. The DON stated she did not have any nursing notes explaining why the nurses did not complete the skin assessments weekly for Resident #2. Record review of a facility policy titled, Charting and Documentation, revised [DATE], revealed all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. Record review of a facility policy titled, Wound Care, revised [DATE], revealed the following information should be recorded in the resident's medical record: The type of wound care given. The date and time the wound care was given. The position in which the resident was placed. The name and title of the individual performing the wound care. Any change in the resident's condition. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. How the resident tolerated the procedure. Any problems or complaints made by the resident related to the procedure. If the resident refused the treatment and the reason(s) why.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F880 S/S E Based on observation, interview, and record review, the facility failed to maintain an infection prevention program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 facilities reviewed for infection control. 1. LVN B did not perform proper hand hygiene after touching contaminated resident surfaces or before entering other resident rooms. 2. Resident #2's had no sign on door notifying of transmission-based precautions or see nurse before entering while Resident #2 had pneumonia with coughing. No PPE was available outside of Resident #2's door. 3. Two unidentified residents sitting less than 6 feet apart eating snacks in front of the nursing station (located between warm and hot halls) without masks on. 4. There was no sign or posting on the closed double doors before entering the warm zone (group of rooms dedicated to residents under 14 day quarantine such as new admissions, readmissions from hospital or residents with potential COVID symptoms awaiting test results) (hall 100). 5. There was no hand sanitizer on the 100 hall, which is a quarantined hall, other than what is inside resident bathrooms. 6. LVN B did not have a face mask over her nose while she preform personal care resident #2 and #4. This failure could place residents who reside in the facility and require care at risk for cross-contamination and infection. Findings included: 1. Observation on 8/26/20 at 3:22 pm revealed LVN B entered Resident #4's room and moved a walker. Then, LVN B exited Resident #4's room and did not perform hand hygiene. Next, LVN B entered Resident #2's room and touched the resident's bedside table and exited without performing hand hygiene. During an interview on 8/31/20 at 12:13 pm, the Director of Nursing stated staff should have performed hand hygiene before entering and after exiting every resident's room and staff should have performed hand hygiene after touching contaminated resident equipment. 2. Record review of Resident #2's Order Summary Report, dated 8/28/20 with active orders as of 8/28/20, revealed Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Order Summary Report, dated 8/28/20 with active orders as of 8/28/20, revealed Resident #2 had an active [DIAGNOSES REDACTED]. Observation on 8/25/20 at 12:01 pm revealed Resident #2, sitting in her room eating lunch with the door open. There were no signs on the door indicating Resident #2 was on transmission-based precautions and to see nurse before entering. Further observation revealed there was

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) no PPE (Personal Protective Equipment) bin outside of her room. Observation on 8/26/20 at 3:22 pm revealed Resident #2, sitting in her room. There were no signs on the door indicating Resident #2 was on transmission-based precautions and to see nurse before entering. Further observation revealed there was no PPE (Personal Protective Equipment) bin outside of her room. During an interview on 8/25/20 at 12:05 pm, Resident #2 stated she was diagnosed with [REDACTED]. During an interview on 8/28/20 at 1:00 PM, CNA C stated she was not aware that Resident #2 had any issue with PNA and first found out Resident #2 had PNA with coughing from the resident herself during her shower on 8/25/20. CNA C stated she wore a face mask and gloves only while providing direct care to Resident #2. CNA C stated she didn't have to wear a gown because no one had a COVID-19 infection. CNA C stated Resident #2 was not on any transmission-based precautions. During an interview on 8/28/20 at 4:18 pm, the DON stated Resident #2 was diagnosed with [REDACTED].#2 started on antibiotics. Resident #2 was in the room by herself and stayed in her room. The DON stated they did not place Resident #2 on transmission-based precautions. The DON stated during direct care the staff should wear a facemask and gloves and a gown was not necessary. 3. Observation on 8/26/20 at 4:20 pm revealed on the long-term care side there were two unidentified residents sitting less than 6 feet apart eating snacks in front of the nursing station (located between warm and hot halls) without masks on. During an interview on 8/31/20 at 12:13 pm, the DON stated the residents should have been wearing masks and been socially distanced more than six feet apart. 4. Observation on 8/25/20 at 11:48 am, the double doors were closed on the recovery hall with a PPE bin outside the doors which included PPE and hand sanitizer, however, there was no sign on the door notifying of the warm zone. During an interview on 8/31/20 at 12:13 pm, the DON stated there should be a sign on the door notifying of the warm zone and she thought there was one there. 5. Observation on 8/25/20 at 11:54 am revealed on hall 100, which is a quarantine hall for residents on [MEDICAL TREATMENT] or with frequent appointments at other facilities, there was no hand sanitizer available in the hall. During an interview on 8/31/20 at 12:13 pm, the DON stated there should be hand sanitizer available on each hall, including hall 100, and she expected all staff to perform hand hygiene each time they exited a resident room. 6. Observation on 8/26/20 at 3:22 pm, LVN B providing care on her unit assigned unit did not have her face mask over her nose, but once she saw the Surveyor, she placed it over her nose. During an interview on 8/31/20 at 12:13 pm, the DON stated all staff should wear their facemasks properly, over their nose, at all times while in the facility, unless they are in the break room. Record review of a facility policy titled, Isolation - Categories of Transmission-Based Precautions, revised April 2010, revealed In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets (larger than 5 microns in size) that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning). Examples of infections requiring Droplet Precautions include but are not limited to invasive [MEDICATION NAME] influenzae type B disease including meningitis, pneumonia, epiglottitis [MEDICAL CONDITION]; Signs Used to Alert Staff of Droplet Precautions: The facility will implement a system to alert staff to the type of precaution resident requires. Record review of a facility document titled, COVID-19 Surveillance and Emergency Action Plan, implemented 3/5/20, revealed essential healthcare personnel, and employees are not required to wear face masks upon entry unless necessary for transmission-based precautions, including an update on 4/1/20, revealed anyone entering facility will wear mask while in facility at all times. However, this facility document did not address the proper way to wear face masks. Record review of a facility document titled, Handwashing/Hand Hygiene, revised June 2010, revealed Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies and in most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for after contact with contaminated equipment or after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident.