| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676441 | A. BUILDING _____ B. WING _____ | 07/17/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| THE HEIGHTS OF ALAMO | 1214 S. ALAMO ROAD ALAMO, TX 78516 |

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 0726<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility nursing staff failed to demonstrate competencies and skills sets necessary to care for residents' needs, as identified through resident assessments and described in the plan of care, for one Resident (R#1) of two residents reviewed for nursing competency, in that: Nursing staff did not document R#1's vital sign readings. This failure could put residents at risk for inadequate care. Findings included: Record review of R#1's electronic medical record revealed R#1 was an [AGE] year-old female who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Annual Minimum Data Set (MDS) assessment, dated 07/04/20, revealed R#1: -had severely impaired cognition, and -required extensive assistance from staff for Activities of daily living. Record review of R#1's comprehensive care plan, date initiated 03/07/20, revealed: Resident has potential for alteration of well-being. Resident is at risk for infection and emotional distress due to measures in place to minimize and associated risks of communicable disease response COVID-19. Record review of R#1's undated comprehensive care plan revealed R#1 had a self-care deficit for Activities of daily living due to dementia. Record review of R#1's vital signs revealed the last documented reading entry for temperature was on 07/08/20 (98.0). Record review of R#1's vital signs revealed the last documented reading for pulse was 07/08/20 (70 bpm). Record review of R#1's vital signs revealed the last documented reading for O2 stats was on 07/01/20 (96.0) Record review of R#1's Medication Administration Record [REDACTED]. There were no actual readings documented for vital signs from 07/01/20 to 07/16/20. There was one check mark from 07/01/20 to 07/16/20. In an interview on 07/16/20 at 10:31 a.m., the DON said R#1's roommate presented signs and symptoms of COVID-19 on 07/09/20 and the roommate was moved to another hall. The DON said R#1 stayed in her room, under observation. The DON said staff documented when they went inside the room, but R#1 was not under isolation. The DON said R#1 and her roommate were tested for COVID-19 on 07/06/20 and both tests were negative. The DON said R#1's roommate's COVID-19 results came back on 07/14/20 and were positive. In an interview on 07/16/20 at 4:05 p.m., the DON said R#1's only recorded vital signs readings were on 07/08/20. The DON said nurses were documenting in the MARS that vital signs were checked but did not document the readings. The DON said a nurse clarified the orders for vital signs but did not add the parameters in the MAR. The DON said nursing staff could record the readings in the nurses notes if there was an abnormal reading. She said nurses documented by exception. Record review of R#1's nurses progress notes revealed there were no vital signs documented. In an interview on 07/16/20 at 5:00 p.m., LVN A said a normal temperature was a temperature no greater than 99.7. LVN A said normal O2 sats would depend on what the physician ordered, but she thought below 90 would be abnormal. LVN A said abnormal respirations were anything below 20. LVN A said if any of the readings were abnormal, nurses needed to communicate with the DON and the Physician. In an interview on 07/16/20 at 5:03 p.m., the DON said the facility followed CDC guidelines for vital signs. The DON said staff was aware to notify her and the physician if vital signs were abnormal. In an interview on 07/17/20 at 8:35 a.m., the DON said there was no written facility policy for vital signs. The DON said having a record with vital sign readings documented would present a clear picture of the resident's vital signs. She said if nurses were not reporting anomalies it was because there were none. The DON said when a nurse called to clarify R#1's order, she did not input the values on the MARS, so there was no place to record them. The DON said vital signs could have been recorded on the vital signs tab in the electronic record, like they were doing before. In an interview on 07/17/20 at 10:28 a.m., LVN B said when adding an order in the MARS there was a tab, supplemental doc in which values could be added. LVN B said by doing that a nurse could have the space to document a vital sign reading. LVN B said having vital signs documented would help a doctor or a nurse provide care. LVN B said nurses could also document vital signs in the nurses notes or under the vital sign tab. In an interview on 07/17/20 at 10:38 a.m., LVN C said she did not remember why she did not include values for the vital signs for R#1 when adding the order. LVN C said adding values to an order could be done. She said abnormal temperature was above 99.5, and O2 abnormal sats were below 95. LVN C said other nurses could have different vital sign abnormal values. LVN C said nurses needed to report abnormal readings to the DON and the physician. LVN C said, in the case of R#1, it was important to record the vital sign readings because R#1's roommate was positive for COVID-19. The facility's undated policy on Standards of Nursing Practice revealed: Objective: our community espouses the use of nursing process in order to deliver appropriate care and services for each resident. . |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate and administering of all drugs to meet the needs of each resident, for one Resident (R#2) of one resident reviewed for medications. The facility left R#2's medication on his bedside table. This failure could place residents at risk of not receiving their medications as ordered by the physician. The findings were: Record review of R#2's MDS assessment revealed he was a [AGE] year-old male who: -had difficulty hearing (moderately impaired), -had clear speech, -was able to make himself understood, -was able to understand others, -had moderately impaired vision, and -was able to complete a Brief Interview for Mental Status. Observation on 07/14/20 at 2:34 p.m. revealed R#2 in bed. On R#2's bedside table there was a cup with coins with a red round medication tablet. Next to it was a medicine cup, with half a white medication tablet. In an interview on 07/14/20 at 2:40 p.m., LVN D said the medications should not be left on the resident's bedside table. In an interview on 07/14/20 at 2:50 p.m., R#2 said a couple of gals (employees) left the medication on his bedside table, in case he needed them later on. In an interview on 07/14/20 at 3:41 p.m., the DON said if a resident did not want to take the medication at the time it was being administered by staff, staff were not to leave the medication and were to verify that the resident took the medication. Record review of the facility's policy on Medication Administration revealed: 7. Observe that the resident swallows oral drugs. Do not leave medications with the resident to self-administer unless the resident is approved for self-administration of the medication. |
| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** |

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 0842<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility nursing staff failed to maintain medical records on each resident that are complete and accurately documented, for one Resident (R#1) of two residents reviewed for medical records, in that: Nursing staff did not document R#1's vital sign readings. This failure could put residents at risk for inadequate care.<br>Findings included: Record review of R#1's electronic medical record revealed R#1 was an [AGE] year-old female who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Annual Minimum Data Set (MDS) assessment, dated 07/04/20, revealed R#1: -had severely impaired cognition, and -required extensive assistance from staff for Activities of daily living. Record review of R#1's comprehensive care plan, date initiated 03/07/20, revealed: Resident has potential for alteration of well-being. Resident is at risk for infection and emotional distress due to measures in place to minimize and associated risks of communicable disease response COVID-19. Record review of R#1's undated comprehensive care plan revealed R#1 had a self-care deficit for Activities of daily living due to dementia. Record review of R#1's vital signs revealed the last documented reading entry for temperature was on 07/08/20 (98.0). Record review of R#1's vital signs revealed the last documented reading for pulse was 07/08/20 (70 bpm). Record review of R#1's vital signs revealed the last documented reading for O2 stats was on 07/01/20 (96.0) Record review of R#1's Medication Administration Record [REDACTED]. There were no actual readings documented for vital signs from 07/01/20 to 07/16/20. There was one check mark from 07/01/20 to 07/16/20. In an interview on 07/16/20 at 10:31 a.m., the DON said R#1's roommate presented signs and symptoms of COVID-19 on 07/09/20 and the roommate was moved to another hall. The DON said R#1 stayed in her room, under observation. The DON said staff documented when they went inside the room, but R#1 was not under isolation. The DON said R#1 and her roommate were tested for COVID-19 on 07/06/20 and both tests were negative. The DON said R#1's roommate's COVID-19 results came back on 07/14/20 and were positive. In an interview on 07/16/20 at 4:05 p.m., the DON said R#1's only recorded vital signs readings were on 07/08/20. The DON said nurses were documenting in the MARS that vital signs were checked but did not document the readings. The DON said a nurse clarified the orders for vital signs but did not add the parameters in the MAR. The DON said nursing staff could record the readings in the nurses notes if there was an abnormal reading. She said nurses documented by exception. Record review of R#1's nurses progress notes revealed there were no vital signs documented. In an interview on 07/16/20 at 5:00 p.m., LVN A said a normal temperature was a temperature no greater than 99.7. LVN A said normal O2 sats would depend on what the physician ordered, but she thought below 90 would be abnormal. LVN A said abnormal respirations were anything below 20. LVN A said if any of the readings were abnormal, nurses needed to communicate with the DON and the Physician. In an interview on 07/16/20 at 5:03 p.m., the DON said the facility followed CDC guidelines for vital signs. The DON said staff was aware to notify her and the physician if vital signs were abnormal. In an interview on 07/17/20 at 8:35 a.m., the DON said there was no written facility policy for vital signs. The DON said having a record with vital sign readings documented would present a clear picture of the resident's vital signs. She said if nurses were not reporting anomalies it was because there were none. The DON said when a nurse called to clarify R#1's order, she did not input the values on the MARS, so there was no place to record them. The DON said vital signs could have been recorded on the vital signs tab in the electronic record, like they were doing before. In an interview on 07/17/20 at 10:28 a.m., LVN B said when adding an order in the MARS there was a tab, supplemental doc in which values could be added. LVN B said by doing that a nurse could have the space to document a vital sign reading. LVN B said having vital signs documented would help a doctor or a nurse provide care. LVN B said nurses could also document vital signs in the nurses notes or under the vital sign tab. In an interview on 07/17/20 at 10:38 a.m., LVN C said she did not remember why she did not include values for the vital signs for R#1 when adding the order. LVN C said adding values to an order could be done. She said abnormal temperature was above 99.5, and O2 abnormal sats were below 95. LVN C said other nurses could have different vital sign abnormal values. LVN C said nurses needed to report abnormal readings to the DON and the physician. LVN C said, in the case of R#1, it was important to record the vital sign readings because R#1's roommate was positive for COVID-19. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, in one of one facility. CNA F did not change gloves or do hand hygiene between resident care for Resident (R) #5 and R#6. This failure could place residents at risk of infection.<br>Findings included: Record review of R#5 face sheet revealed R#5 was a [AGE] year-old female who was admitted to the facility on [DATE]. R#5's [DIAGNOSES REDACTED]. Record review of R#5's Quarterly MDS assessment, dated 06/29/20, revealed<br>R#5: -had adequate hearing, -had unclear speech, -was sometimes understood by others, -was sometimes able to understand others, and -required total assistance by two staff for bed mobility, transfers, dressing and personal hygiene. Record review of R#6's face sheet revealed R#6 was an [AGE] year-old female who was admitted to the facility on [DATE]. R#6's [DIAGNOSES REDACTED]. Record review of R#6's Quarterly MDS assessment, dated 05/02/20, revealed R#6: -had adequate hearing, -had clear speech, -was able to make herself understood, -was able to understand others, -required extensive assistance by two staff for bed mobility, dressing, and personal hygiene, and -required total assistance by two staff for transfers, toilet use, and bathing. Observation on 07/14/20 at 3:35 p.m. revealed CNA F donned clean gloves and transferred R#6 to bed. Without performing hand hygiene and wearing the same gloves, CNA F walked over to R#5 and adjusted R#5's brief and pants, and covered R#5 with the sheet. Without performing hand hygiene and wearing the same gloves, CNA F walked back to R#6 and continued to adjust the bolsters on R#6's bed, and her sheets. CNA F then removed gloves and adjusted R#5's sheets. No hand hygiene was performed. In an interview at the time of the observation, CNA F said changing gloves and hand hygiene should be done between each resident. In an interview on 07/14/20 at 3:41 p.m., the DON said staff are to change gloves, and wash hands or hand sanitize between each resident. Record review of the facility's Infection Prevention and Control Program revealed: 6. Outbreak Management 1) Determining the presence of an outbreak 2) Managing the affected residents 3) Preventing the spread to other residents 7. Prevention of Infection following established general and disease-specific guidelines such as those of the Centers for Disease Control. |