STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. BUILDING _____ B. WING _____	**05/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDGEWATER CARE CENTER	**1213 WATER ST KERRVILLE, TX 78028**

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 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident has a right to be treated with respect and dignity for 1 of 4 residents (Resident #2) reviewed for dignity, in that: The Wound Care Nurse left Resident #2's door opened when she provided wound care to the resident. This deficient practice could place residents at-risk of loss of dignity. The findings were: Record review of Resident #2's face sheet, 05/01/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Annual MDS, dated [DATE], revealed the resident had a BIMS score of 13, which indicated the resident was cognitively intact, and required extensive assistance with one-person physical assist to bed mobility and transfer. Record review of Resident #2's physician orders, dated 05/01/2020, revealed the resident had the order of, Left foot plantar dressing: clean with normal saline and apply [MEDICATION NAME] and dry dressing every Monday, Wednesday, and Friday (order dated 02/24/2020). Observation of wound care for Resident #2 on 05/01/2020 at 11:50 a.m. revealed the Wound Care Nurse entered Resident #2's room and did not close the resident's door or pull the resident's privacy curtain closed. Further observation revealed the Wound Care Nurse performed a dressing changing to Resident #2's wound with the door opened during whole process. Further observation revealed the whole process of wound care for Resident #2 was exposed to the 300-hallway. During an interview with the Wound Care Nurse on 05/01/2020 at 12:21 p.m., the Wound Care Nurse confirmed she did not close the resident's door or pull the resident's privacy curtain closed during wound care. The Wound Care Nurse confirmed whole process of wound care for Resident #2 was exposed to the 300-hallway. During an interview with the DON on 05/01/2020 at 3:30 p.m., the DON confirmed the Wound Care Nurse should have provided full privacy to Resident #2 during wound care. Record review of the facility's policy titled Quality of Life-Dignity, revised 10/2009, revealed, policy Statement - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 to ensure residents' records were maintained on each resident that were complete, accurately documented, and in accordance with accepted professional standards and practices for 1 of 4 residents (Resident #1) reviewed for records, in that: The Wound Care Nurse and LVN A did not document on the Wounds Flowsheet that Resident #1 had been provided wound care as ordered. This deficient practice could place residents at risk of improper care due to inaccurate records. The findings were: Record review of Resident #1's face sheet, dated 05/01/2020, revealed the resident was admitted to the facility on [DATE], and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #1's physician orders [REDACTED]. 30 days (order dated 04/28/2020). Record review of Resident #1's Wound Flowsheet for April 2020 revealed there was no documentation for 0[DATE]7/2020, 0[DATE]8/2020, 0[DATE]9/2020, 04/20/2020, 04/21/2020, 04/22/2020, 04/25/2020, and 04/26/2020 (the dates were blank) that indicated the resident was provided with wound care as ordered on those dates. Record review of Resident #1's nursing note by LVN A, dated 04/22/2020, revealed LVN A documented to the nursing note, Dressing to both feet changed. During an interview with the Wound Care Nurse on 05/01/2020 at 12:21 p.m., the Wound Care Nurse confirmed she provided wound care to Resident #1 as ordered on [DATE], 0[DATE]8/2020, 0[DATE]9/2020, 04/25/2020, and 04/26/2020. The Wound Care Nurse further confirmed she did not document on Resident #1's Wound Flowsheet. During an interview with LVN B on 05/01/2020 at 2:37 p.m., the LVN B stated she saw LVN A provided wound care to Resident #1 on 04/20/2020, 04/21/2020, and 04/22/2020 because LVNs A and B worked together to the 300-hallway at those dates. During an interview with the DON on 05/01/2020 at 3:30 p.m., the DON confirmed LVN A and the Wound Care Nurse provided wound care to Resident #1 as ordered on [DATE], 0[DATE]8/2020, 0[DATE]9/2020, 04/20/2020, 04/21/2020, 04/22/2020, 04/25/2020, and 04/26/2020, but they did not document the wound care on Resident #1's Wound Flowsheet. The DON confirmed LVN A and the Wound Care Nurse should have documented on Resident #1's Wound Flowsheet after providing care immediately. Record review of the facility's policy and procedure titled Charting and Documentation, dated 04/2008, revealed, 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.

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.