STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676304	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE VILLAGE HEALTHCARE LTC PARTNERS, INC	914 N BRAZOSPORT BLVD CLUTE, TX 77531

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 interview, and record review, the facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to prevent development of pressure injuries for 1 of 3 residents reviewed for pressure injuries. (CR #1) -The facility did not identify the development of 2 large facility acquired Stage III pressure injuries for CR #1. -The facility did not prevent the development of two facility acquired Stage III pressure injury for CR #1. This failure could place 3 residents who had pressure injuries at risk for new development or worsening of existing pressure injuries. Findings included: Record review of CR #1's admission record revealed she was an [AGE] year-old female originally admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of CR #1's Significant Change Minimum Data Set ((MDS) dated [DATE] revealed a cognitive pattern BIMS score of 10 indicating she was moderately impaired. CR #1's Activities of Daily Living (ADL) Assistance revealed transfers required extensive assistance with 2 persons assisting her. Bed mobility, locomotion on unit, locomotion off unit, dressing, toilet use, and personal hygiene required extensive assistance with one person assisting her. CR #1 required total assistance with bathing with one person assisting her. CR #1 triggered for risk of pressure ulcers but was not found to have any stage able pressure ulcers. The resident triggered for unstageable pressure ulcer with slough and/or eschar on the foot. The devices for skin conditions are pressure reducing device for chair, pressure reducing device for bed, nutrition or hydration intervention, pressure injury care, application of ointment/medication and application of dressings to feet. Record review of CR #1's Care Plan dated 6/2/2020 revealed impaired cognitive function or impaired thought processes road track (r/t) dementia and the interventions included keep routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion. Resident has potential for pressure injury development r/t limited physical mobility with interventions/tasks to follow facility policies /protocols for the prevention of skin breakdown. Inform CR #1's family of any new skin breakdown and notify nurse immediately of any new areas of skin breakdown: Redness, blisters, bruises, discoloration noted during bath or daily care. Initiate a stop and Watch Alert for changes in skin. CR #1 is on Anticoagulant therapy (Eliquis) r/t [MEDICAL CONDITION] with interventions to daily skin inspection. Report abnormalities to the nurse. She had potential impairment to skin integrity r/t [DIAGNOSES REDACTED]. Keep fingernails short. Encourage good nutrition and hydration in order to promote healthier skin. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Record review of weekly skin assessment dated [DATE] at 9:32 a.m. revealed normal skin color, warm temperature, no bruises, skin tears, abrasions, lacerations, surgical incisions, rashes, and no moisture. Record review of weekly skin assessments from June 2020 to 7/21/20 did not reveal any skin conditions related to CR #1's buttocks. Record review of Nurses Notes from 6/1/2020 to 7/26/2020 did not reveal any skin conditions related to CR #1's buttocks. Record review of CR #1's weekly ulcer assessment dated [DATE] at 2:33 p.m. revealed ulcer on right buttock identified on 7/27/2020 with length 6.7 cm and width 7.8 cm depth 0.0 with wound bed character being moist, redness around wound, and [MEDICAL CONDITION] present. The interventions are to cleanse, apply xeroform to open site, apply [MEDICATION NAME] to closed site, cover with clean foam dressing daily. The pressure reducing devices revealed an air mattress, wheelchair cushion, pillows to float heels and podus boot. Notification to nurse practitioner was sent and they received physician orders. Record review of CR #1's weekly ulcer assessment dated [DATE] at 2:15 p.m. revealed ulcer of left buttock identified on 7/27/2020 with length 3.5 cm and width 3.0 cm and depth 0.0, multiplying the length and width is 1.8-12.0, no tunneling, moist bed character, red around wound, and [MEDICAL CONDITION] present. The interventions are to cleanse, apply xeroform to open site, apply [MEDICATION NAME] to closed site, cover with clean foam dressing daily. The pressure reducing devices revealed an air mattress, wheelchair cushion, pillows to float heels and podus boot. Notification to nurse practitioner was sent and they received physician orders. Record review of CR #1's nursing progress notes dated 7/27/2020 at 3:31 p.m. revealed this nurse found DTI to left buttock and right buttock. Both right and left buttock have open areas to DTI sites. DTIs with open areas were reported to Nurse Practitioner and representative party. In an interview on 8/13/2020 at 11:30 a.m. with ADON she said she was the one who identified CR #1's wound and that it was not noted before. On 7/21/2020 the facility completed her weekly skin assessment and they did not observe any bruising. CR #1 was getting her shower and the CNA said dry blood was on the resident's brief. The resident received her showers on Monday, Wednesday and Friday. The ADON said there were no pressure sores noted the day before. The ADON said no one identified the pressure sore before. CR #1 was on an air mattress and getting supplements. She notified the physician and he gave the resident a treatment plan. CR #1 was sent out to the hospital that day because she had pneumonia and she was not eating right. In an interview on 8/13/2020 at 11:40 a.m. with CNA A she said CR #1 had what looked like elephant skin that was brown and blue. She said she care for CR #1 before she went out to the hospital and she did not see any wounds. She also cared for CR #1 a week or two before the resident left. CNA A said the resident had always looked that way since she started working at the facility in June. CNA A said sometimes the staff would put zinc on it. In an interview on 8/14/2020 at 12:15 p.m. with Charge Nurse she said CR #1 did not have any pressure sores, only on her heel. She said it does not normally happen that a large pressure sore just appears. The Charge Nurse said CR #1 had not been eating nutritiously for some time. CR #1 was not accepting the shakes and her family member was bringing her food. The Charge Nurse said the facility staff could not put the resident on her right side and that they normally put her on her left side because she swelled so bad due to paralysis. CR #1 would always turn back over to her back. She said they made frequent observations and due to [MEDICAL CONDITION], she seldom got up in her wheelchair. CR #1 was not compliant with changing her briefs and she had been at the facility for years. Record review of CR #1's Care Plan dated 6/2/2020 revealed an ADL Self Care Performance Deficit r/t flaccid [MEDICAL CONDITION] affecting right dominant side and that she used removable soft brace on right hand. The goal was that CR #1 would maintain current level of function in bed, mobility, transfers, eating, dressing, toilet use and personal hygiene. None of the interventions stated that resident could not lay on her right side. In an interview on 8/14/2020 at 12:25 p.m. with CNA B she said she would talk CR #1 into getting her showers and that she did not want to get up a lot. CR #1 appeared depressed because she no longer did the things she used to do, like playing bingo. CNA B had been previously been assigned to care for CR #1 and she stopped wanting to eat her favorite foods and that she did not know how the wound just appeared and no one saw it. In a telephone interview while at the facility on 8/14/2020 at 12:49 p.m. with the ADON, who is also the wound care nurse said CR #1 had her right heel stage III pressure ulcer since March. The ADON said she did not believe that no one saw the pressure ulcer. CR #1 had not been eating well and her weight was declining. The ADON said she had seen pressure ulcers develop overnight. She said a CNA found the pressure ulcer and reported it to her, but she could not recall who it was. The resident got her shower on a Monday and the CNA noted that CR #1 had dried blood. When the facility staff put on her brief they found the pressure sores. The ADON said the CNA's changed the resident over the weekend and they had not identified any pressure sores The last weekly skin assessment was on 7/21/2020. CR #1 was not due for another skin assessment until 7/28/2020. The ADON said the wound care doctor had not been to the facility for a few weeks. The wound care doctor did not come to the

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) facility on [DATE]. The Charge Nurses complete the weekly skin assessments. CR #1 was repositioned every 2 hours, but a lot of times she moved out of position. She was on an air mattress since day 1 of being in the facility. If facility staff know the resident is non-compliant, they should go back to the resident more frequently. The ADON said the facility staff tried to do that and they educated the resident as well. In a telephone interview while at the facility on 8/14/2020 at 1:10 p.m. with CNA A said CR #1 had elephant skin and she asked the Nurse what it was, and they said it was scar tissue from the past. She said she had never seen scar tissue look like that before. It was brownish, but it stayed the same. CNA A had never seen such a large pressure sore develop overnight. In a telephone interview on 8/14/2020 at 1:40 p.m. with Local Wound Care she said the Wound Care Physician had not seen CR #1 for wound care for pressure wounds to her buttocks while at the facility. In an interview on 8/14/2020 at 2:00 p.m. with CNA C she said CNA B was giving her shower on 7/27/2020 and that is when the pressure ulcers were discovered on her buttocks. When her shower was done, they brought the resident to her room and laid her down and looked at her buttocks and they saw the pressure sores. The wounds were reported to the Charge Nurse, the ADON and the DON came to see the wounds. CNA C said the wound came out of nowhere. CNA C said the pressure sore was not deep. In an interview on 8/14/2020 at 2:30 p.m. with the Administrator said she had seen pressure ulcers develop quickly before. She said CR #1 did not let them change her brief and she sat in the wheelchair on her buttocks. The Administrator said the odor would be strong. CR #1 was also non-compliant in repositioning because she wanted to watch television. CR #1 did not want to be turned and she sat in urine. Sometimes the facility had to call the residents family member or CNA B that she liked to get her to change her brief. Record review of CR #1's Significant Change Minimum Data Set ((MDS) dated [DATE] revealed in section for Behavior that CR #1 had a score of 0 for resisting care, revealing behavior was not exhibited. The question was: Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Record review of the Care plan dated 6/2/2020 did not reveal that CR#1 was care planned for behaviors or denying care. In an interview on 8/14/2020 at 2:50 p.m. with the DON she said the facility had an air mattress, supplements, podus boot for the heel wound, wheelchair cushion, floated heels, Vitamin C, arginate, liquid protein, stayed in contact with family member, they did weekly updates, and educated the resident about repositioning. Sometimes CR #1 allowed the facility staff to reposition her. The facility tried to turn the resident's bed, but she would not allow them to do it. CR #1 was sent out to a local hospital on [DATE] because of pneumonia and she was septic from the weekend to Monday. In an interview on 8/14/2020 at 3:20 p.m. with the DON she said the ADON oversees the assessments, but the Charge Nurses complete the weekly assessments. The DON said she stages the pressure ulcers. The DON said the facility in serviced staff to tell the nurse about new skin conditions such as bruises, scratches, wounds, and red area. The DON said the staff turn every resident who cannot do it for themselves every 2 hours. The DON said CR#1 had a Stage III pressure ulcer on her left and right buttock. Record review of facility policy on Pressure Ulcer Protocols and Prevention dated 10/1/2016 revealed Nursing home residents, due to comorbidities and underlying clinical conditions, may develop pressure ulcers during their stay at the facility, but pressure ulcer prevention should be performed daily to deter ulcers from forming .This includes all residents not just high risk for pressure ulcer residents should be monitored closely. Here are some examples of preventative measures, but this list is not encompassing: * Turn and reposition every 2 hours or more frequently as needed. * Pressure relieving devices, such as: heel protectors, wedges, mattresses, etc. * Frequent incontinent care, if resident is incontinent, if not frequent rounds for accidents. * Barrier creams to be applied as needed. * Any changes in skin should be reported to charge nurse immediately, especially on shower days. * Skin assessments weekly to monitor and look for changes in skin. * Quarterly pressure ulcer risk assessments or when a significant change is noted. * Monitor weights monthly, and place on interventions for any flagging significant weight loss.