STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E629	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SARAH ROBERTS FRENCH HOME	1315 TEXAS AVE SAN ANTONIO, TX 78201

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 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure that a resident who was fed by enteral means received the appropriate treatment and services to prevent complications for 1 of 9 residents (#44), in that: Resident #44's tube feeding formula was not being administered as ordered by the physician. This deficient practice could affect residents who receive enteral feedings and could result in residents not receiving the appropriate nutrition. The findings were: Review of Resident #44's face sheet (no date) revealed she was admitted on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident #44's consolidated physician orders [REDACTED].=1610cc/1932 kcal (kilo calorie) and 96.6grams of protein every shift for a [DIAGNOSES REDACTED]. Review of Resident #44's MAR for March 2020 revealed her enteral feeding downtime was from 8 AM- 9 AM Review of Resident # 44's care plan dated 2/13/2020 revealed she required a feeding tube x 23 hours, related to NPO (nothing by mouth) status. Observations on 3/10/20 at 2:50 PM, 3/11/20 at 9:23 AM and 3/11/2020 at 9:33 AM revealed Residents # 44's enteral feeding pump was off. In an interview on 3/11/20 at 9:31 AM CNA A revealed Resident #44 was back in her room from a shower and she failed to notify the nurse that the resident's enteral feeding pump was off. In an interview on 3/11/20 at 9:33 AM LVN B confirmed Resident #44 enteral feeding pump was off. LVN B stated CNA A did not let her know that Resident #44 was back in her room from her shower, so she could turn the tube feeding pump back on.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observations, interview and record review the facility failed to post the nurse staffing data on a daily basis at the beginning of each shift and failed to maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, for 3 of 3 (3/9-11/2020) days reviewed, in that: 1. The posted nurse staffing data posted was not updated for 13 days. 2. The facility was unable to provide the postings for nurse staffing prior to 2/27/2020. These deficient practices could affect residents and could result a resident and visitors being unaware of staffing in the facility. The findings were: 1. Observations on 3/09/2020 at 11:43 AM,3/10/2020 at 2:10 PM and 3/11/2020 at 8:28 AM revealed the posting titled Nursing Staff Directly Responsible for Resident Care was dated 2/27/2020. In an interview on 3/11/20 at 8:30 AM the MDS nurse confirmed the Nursing Staff Directly Responsible for Resident Care was dated 2/27/2020. 2. The DON was unable to provide documentation for any previous nurse staffing information for the past 18 months. In an interview on 03/11/20 at 8:36 AM the DON confirmed the Nursing Staff Directly Responsible for Resident Care was dated 2/27/2020 and was unable to provide documentation for any previous nurse staffing information for the past 18 months. Review of the policy on Posting Direct Care Daily Staffing Numbers dated April 2006 revealed 3. b. the date for which the information is posted and 8. Records of staffing information for each shift will be kept for a minimum of 18 months or as required by state law.
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 to maintain medical records on each resident that were accurate and complete in accordance with accepted professional standards and practices for 4 of 32 residents (#46, #44, #40 and #55), in that: 1. Resident #46's last weekly skin assessment for the stage II pressure ulcer on her coccyx was documented on 2/27/20. 2. Resident #44's last wound/skin healing record for her stage III pressure ulcer to her left heel was documented on 2/10/20. 3. a. Resident #40's medication administrations were not documented on the MAR for: [MEDICATION NAME] (hypertension) on 2/13/2020 and 2/15/2020, [MEDICATION NAME] (outbursts of crying/laughing) on 2/9/20 and 2/13/20, Senna syrup (stool softener) on 2/13/20 and 2/23/20 and Tylenol with [MEDICATION NAME] (for pain) on 2/13/20. b. Resident #40's pain assessments were not documented on the TAR for 2/16/20, 2/19/20, 2/27/20, 2/28/20 and 2/29/20. c. Resident # 40's indwelling catheter care was not documented on the TAR for 2/16/20, 2/19/20, 2/28/20 and 2/29/20. 4. a. Resident #55's heart rate and blood pressure were not documented on the MAR for administration of [MEDICATION NAME] on 1/8/20 and 1/27/20, [MEDICATION NAME] on 1/8/20, 1/2/20 and 1/27/20, [MEDICATION NAME] on 1/8/20, 1/24/20 and 2/28/20 as ordered prior to administration of hypertension medications. b. Resident #55's pain assessments were not documented on the TAR for 1/20/20, 1/22/20, 1/30/20 and 1/31/20. These deficient practices could affect residents and could result in inaccurate information on resident records. The findings were: 1. Review of Resident # 46's face sheet dated 3/11/2020 revealed she was admitted on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident # 46's consolidated physician orders [REDACTED]. Document findings on the Weekly Skin Assessment sheet by indicating skin issues noted on drawing of body and marking Yes/No to potential skin issues. Review of Resident #46's Quarterly MDS dated [DATE] revealed in section cognition patterns 3/15 (severely cognitively impaired) and in section skin conditions- stage II with pressure ulcer care. Review of Resident #46's Care Plan dated 6/5/2019 revealed she had a pressure ulcer on her coccyx and it was being treated. Review of Resident #46's pressure injury report dated [DATE]20 and [DATE] revealed she had a facility acquired stage II pressure ulcer to her coccyx. Review of Resident # 46's weekly skin assessment dated [DATE] revealed no wound/skin healing record documentation regarding Resident #46's pressure ulcer, after 2/27/2020 (includes staging, measurements, skin observation and pain assessment). Interview on 03/10/20 at 11:36 AM LVN C confirmed there were no wound/skin healing record documentation, but it was documented on the treatment administration record (TAR) as completed for Resident #46's coccyx stage II pressure ulcer for (NAME)2020. 2. Review of Resident #44's face sheet (no date) revealed she was admitted on [DATE] and readmitted on [DATE] with the [DIAGNOSES REDACTED]. Review of Resident # 44's consolidated physician orders [REDACTED]. Document findings on the Weekly Skin Assessment sheet by indicating skin issues noted on drawing of body and marking Yes/No to potential skin issues. Review of Resident #44's Quarterly MDS dated [DATE] revealed for cognition pattern 3/15 (severely impaired) and section Skin condition stage III with pressure ulcer care. Review of Resident #44's Care Plan dated [DATE] revealed she had a stage II pressure ulcer on her left heel. Review of the facility matrix dated [DATE]20 revealed Resident # 44 had a stage III pressure ulcer to her left heel. Review of Resident #44's Pressure injury report dated [DATE]20 and [DATE] revealed she was admitted with a left heel stage III pressure ulcer. Review of Resident # 44's wound/skin healing records was dated 2/10/2020 for her left heel. This was the last assessment done and should have been completed weekly. Observation on 03/10/20 at 9:44 AM with LVN C revealed Resident #44's left heel was not open. During an interview on 03/10/20 at 9:30 AM with the DON, he stated there were no

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

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Feb/(NAME)2020 skin/pressure assessments for Resident #44. During an interview on 03/10/2020 at 9:45 am with LVN C confirmed Resident #44's left heel skin was not open. Review of the policy for Pressure Ulcer Risk assessment dated (NAME)2005 revealed Assessment 2. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 3. Review of Resident #40's face sheet (undated) revealed an admission date of [DATE] with a readmission on 1/23/2019 with [DIAGNOSES REDACTED]. Review of Resident #40's consolidated physician orders [REDACTED].< (less than) 100 or heart rate <60 (start 1/23/19); [MEDICATION NAME] 20-10 mg twice daily per gastric tube (start 7/2/19), Senna Syrup 8.8 mg/5 ml twice daily per gastric tube (start 1/23/19) and Tylenol-[MEDICATION NAME] #3 300-30 mg three times daily per gastric tube (start 1/23/19). Review of Resident #40's MAR for February 2020 revealed no signature for [MEDICATION NAME] on 2/13/20 at 8 AM. Further review revealed there was no blood pressure documentation or explanation for not giving [MEDICATION NAME] on 2/15/20 at 4 PM. Review of Resident #40's MAR for February 2020 revealed no documentation for [MEDICATION NAME] on 2/9/20 at 8 PM and 2/13/20 at 8 PM. Review of Resident #40's MAR for February 2020 revealed no documentation for Senna Syrup on 2/13/20 at 4 PM, and 2/23/20 at 8 AM. Review of Resident #40's MAR for February 2020 revealed no documentation for Tylenol-[MEDICATION NAME] #3 on 2/13/20 at 3 PM. b. Review of Resident #40's consolidated physician orders [REDACTED]. Review of Resident #40's TAR revealed no documentation for Resident #40's pain assessment for 2/16/20 on 2-10 shift, 2/19/20 on 2-10 shift, and 2/27/20-2/29/20 on 2-10 shift. In an interview on 3/10/20 at 12:00 PM Resident #40 denied any pain or discomfort. Review of Resident #40's TAR revealed no documentation for indwelling catheter care on 2/16/20, 2/19/20, 2/28/20, and 2/29/20 for 2-10 shift. 4. a. Review of Resident #55's face sheet (undated) revealed an admission date of [DATE] and a readmission on 11/2/2019 with [DIAGNOSES REDACTED]. Review of Resident #55's consolidated physician orders [REDACTED]. Review of Resident #55's MAR for January 2020 revealed no blood pressure or heart rate documentation for: [MEDICATION NAME] on 1/8/20 and 1/27/20 at 8 AM [MEDICATION NAME] on 1/8/20 and 1/24/20 at 8 AM, and 1/27/20 at 8 AM and 4 PM. [MEDICATION NAME] on 1/8/20 and 1/24/20 at 8 AM and on 2/28/20 at 8 AM and 4 PM. b. Review of Resident #55's consolidated physician orders [REDACTED]. Review of Resident #55's TAR for January 2020 revealed no documentation for pain assessment on 1/20/20, 1/22/20, and 1/27/20 6-2 shift, 1/30/20 and 1/31/20 for 6-2 shift and 2-10 shift. In an interview on [DATE] at 4:00 PM Resident #55 denied any issues, pain or discomfort and reported that her needs are met. In an interview on 3/11/20 at 3:00 PM the MDS nurse stated there should not be any blanks in the MAR or TAR. Interview with DON on 3/11/20 at 3:00 PM stated there should not be any blanks in MAR or TAR documentation and staff have been trained. In an interview on 3/11/20 at 4:00 PM the medical records clerk revealed when the MAR's and TAR's were turned in, she made a list of all the blanks in documentation and provided it to the DON. Review of facility policy titled Administering Medications policy revised (NAME)2006 read 9. The individual administering the medication must initial the resident's MAR on the appropriate line and date for that specific day before administering the next resident's medication. 12. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication must initial and circle the MAR space provided for that particular drug. 14. Any explanatory note on the reverse side of the MAR must be entered when drugs are withheld, refused, or given other than at scheduled times .