STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676212	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLLEGE PARK REHABILITATION AND CARE CENTER	**1715 MARTIN DR WEATHERFORD, TX 76086**

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 3 (Resident #5, #11, and #12) of 13 residents reviewed for ADLs. The facility failed to provide showers consistently for Residents per the facility bathing schedule. This failure could place residents at risk for poor personal hygiene and a decline in their quality of life. Findings included: Review of Resident #5's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was cognitively intact with a BIMS score of 13 (a score of 13-15 indicated cognitively intact). She required physical help in part of the bathing activity from one staff. Review of Resident #5's Care Plan initiated on 05/15/20 revealed she had ADL self-care deficits and required moderate assistance from one staff for bathing. Review of Resident #5's July 2020 ADL Documentation Report revealed the resident did not receive 9 out of 12 baths. She did not get a bath from 07/02/20 thru 07/08/20 (8 days) and from 07/12/20 thru 07/24/20 (14 days). In an interview and observation on 07/21/20 at 12:35 PM Resident #5 was sitting in her room in her wheelchair. She was dressed but her hair was not combed, and she did not appear to be properly groomed. She said she was not pleased with her care and had not received a shower. Review of Resident #11's MDS dated [DATE] revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was cognitively intact with a BIMS score of 14 (a score of 13-15 indicated cognitively intact). She required physical help in part of the bathing activity from one staff. Review of Resident #11's Care Plan initiated on 05/15/18 revealed she had ADL self- care deficits and required extensive assistance with bathing from two staff. Review of Resident #11's July 2020 ADL Documentation Report revealed the resident did not get 4 out of 12 baths. She did not get a bath from 07/19/20 through 07/27/20 (9 days). In an interview and observation on 07/21/20 at 12:44 PM Resident #11 was in bed, her hair appeared disheveled and she was wearing a hospital gown. She said she was not happy with her care. She said she had not had a shower for the last two weeks. Review of Resident #12 MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated cognitively intact). Review of Resident #12's Care Plan initiated on 05/01/20 revealed she had ADL self-care deficits and required moderate assistance from one staff for bathing. Review of Resident #12's July 2020 ADL Documentation Report revealed the resident did not get 7 out of 12 baths. She did not get a bath from 07/01/20 thru 07/07/20 (7 days) or from 07/22/20 thru 07/27/20 (6 days). In an interview and observation on 07/28/20 at 3:43 PM Resident #12 was in her room. She was well groomed. She said she was upset because she was not receiving assistance with her showers. She said she had to shower herself, but it was difficult for her and she should receive assistance from staff. In an interview on 07/23/20 at 3:30 PM CNA A said staff tried to the get the residents showers done but were not always able to get all of them done. In an interview on 07/24/20 at 4:30 PM the Administrator said the facility had 16 staff out with COVID-19. He said some of the showers may have been missed. He said the facility had contracted with agency staff, but they were not always reliable. In an interview on 07/28/20 at 11:27 AM CNA B said all the showers do not get done but it does not happen very often. In an interview on 07/28/20 at 2:58 PM CNA C said staff were not able to get all the residents' showers done but they try. Review of the facility's un-dated Quality of Care Policy for Activities of Daily living revealed the facility provides the necessary care and services to ensure that each resident attains or maintains the highest practicable physical, mental and psychosocial well-being in accordance with the resident's comprehensive assessment and plan of care.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 (Resident #12) of 13 (Resident #12) residents reviewed for quality of care. The facility failed to ensure Resident #12's wound care was provided, as ordered by the physician. This failure placed residents at risk for worsening wounds and infections. Findings included: Review of Resident #12 MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was cognitively intact with a BIMS score of 15 (a score of 13-15 indicated cognitively intact). Review of Resident #12's Care Plan initiated on 05/01/20 revealed the resident had a surgical wound to her right lower extremity and wound care was to be provided as ordered by the physician and to monitor for signs and symptoms of infection. Review of Resident #12's Physician order [REDACTED]. In an interview on 07/28/20 at 1:21 PM the Wound Care Nurse said this was her first day back to work (07/28/20) in two weeks. She said the nurses were to provide wound care in her absence. During an interview and observation on 07/28/20 at 3:43 PM Resident #12 was in her room. The wound care nurse uncovered the resident's incision to her right lower extremity. The top of the wound was an incision with steri-strips at the bottom of the wound there was a red open area that appeared to the size of a dime. The Wound Care Nurse said the incision was from an abscess and the resident had poor circulation related to her [DIAGNOSES REDACTED]. At this time, the resident said she was upset because she had not been receiving her wound care every day as ordered by her physician. Review of Resident #12's July 2020 Treatment Record revealed to cleanse the resident's right lower extremity surgical wound, a cutaneous abscess, with normal saline, pat dry with gauze, apply [MEDICATION NAME] perorder, [MEDICATION NAME] wash, pack tunneling with idosorb [MEDICATION NAME], cover with ABD, double [MEDICATION NAME] G and ace wrap for compression every day: There was no documentation the treatment was done 6 out of 27 days on 07/11/20, 07/12/20, 07/15/20, 07/18/20, 07/21/20 and 07/24/20. Review of Resident #12's Progress Notes from 07/11/20, 07/12/20, 07/15/20, 07/18/20, 07/21/20 and 07/24/20 did not reveal any documentation regarding her wound care. Review of Resident #12's Weekly Skin Report dated 07/06/20 revealed the right lower leg surgical incision measured 1 x 0.5 x 2.5 cm. Review of Resident #12's Weekly Skin Report dated 07/28/20 revealed the right lower leg surgical incision measured 1.5 x 2.8 x 0.8 cm. In an interview on 07/29/20 at 11:30 AM with the ADON and the Wound Care Nurse, the ADON said that she reviewed Resident #12's July 2020 Treatment Record and Contacted the nurses that were responsible for the resident's wound care on 07/11/20, 07/12/20, 07/15/20, 07/18/20, 07/21/20 and 07/24/20. The Wound Care Nurse said she worked a night shift on 07/15/20 and did the resident's wound care but failed to document on the Treatment Record. The ADON said RN E worked the weekend and was responsible for the resident's wound care on 07/11/20, 07/12/20 and 07/18/20. She said RN F could not remember if she did the wound care on 07/11/20, 07/12/20 and 07/18/20. The ADON said LVN G was out sick today (07/29/20) and when she was contacted about the resident's wound care on

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 07/21/20 she could not remember if the wound care was done. The ADON said LVN H was responsible for the resident's wound care on 07/24/20 but LVN H could not remember if she did the wound care on 07/24/20. Review of Resident #12's Progress Note dated 07/30/20 at 1:52 PM a phone consultation was held with the wound care physician; he stated the wound is stable, continue with current care plan. Follow up in two weeks and to notify him of any changes in condition. Review of the facility's Wound Care Policy and Procedure dated October 2010 revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The preparation included to verify the physician order.
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 observation, interviews, and record reviews, the facility failed to maintain clinical records that were complete and accurate, in accordance with accepted professional standards and practices, for 2 (Resident #5 and #11) of 13 residents reviewed for accuracy of clinical records. The facility failed to provide accurate documentation regarding Resident #5 and #11's activities of daily living. This deficient practice could affect residents and result in errors in care and treatment. Findings included: Review of Resident #5's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was cognitively intact with a BIMS score of 13 (a score of 13-15 indicated cognitively intact). She required physical help in part of the bathing activity from one staff. Review of Resident #5's Care Plan initiated on 05/15/20 revealed she had ADL self-care deficits and required moderate assistance from one staff for bathing. In an interview and observation on 07/21/20 at 12:35 PM Resident #5, who resided on the 200 Hall, was sitting in her room in her wheelchair. She was dressed but her hair was not combed and she did not appear to be properly groomed. She said she was not pleased with her care and had not received a shower. Review of Resident #11's MDS dated [DATE] revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was cognitively intact with a BIMS score of 14 (a score of 13-15 indicated cognitively intact). She required physical help in part of the bathing activity from one staff. Review of Resident #11's Care Plan initiated on 05/15/18 revealed she had ADL self- care deficits and required extensive assistance with bathing from two staff. In an interview and observation on 07/21/20 at 12:44 PM Resident #11, who resided on the 200 Hall, was in bed, her hair appeared disheveled and she was wearing a hospital gown. She said she was not happy with her care. She said she had not had a shower for the last two weeks. An observation and interview on 07/24/20 at 4:00 PM the Administrator provided Resident #5 and #11's July 2020 ADL Documentation Reports. The data was entered into the computer and printed on the report; however, these contained handwritten documentation of showers provided. The Administrator said he would get someone to explain why the reports were handwritten. Review of Resident #5's July 2020 ADL Documentation Report revealed CNA B initialed on 07/01/20, 07/02/20, 07/03/20, 07/04/20, 07/06/20, 07/08/20, 07/13/20, 07/15/20, 07/17/20, 07/20/20, 07/22/20 and 07/24/20. She did not document if a bath was provided or how much assistance the resident required. However, on 07/21/20 - 07/24/20 the resident resided on the 200 Hall and CNA B worked the 400 Hall. Review of Resident #11's July 2020 ADL Documentation Report revealed CNA B initialed a bath was not provided on from 07/20/20-07/24/20; however, she was not assigned to the hall on those dates. An interview and observation on 07/24/20 at 4:05 PM LVN H said the reports could be written in if the internet goes down or if it would be faster to just write in the documentation. She said if the reports were printed and the documentation written in they were kept in the shower notebooks on the halls. On 200 Hall staff could not locate the shower notebook. Reviewed Resident #11's report with LVN H and asked if CNA B had worked the 400 Hall and the 200 Hall in the same day and she said no, I don't know why her initials are on Resident #5 and 11's reports from 07/20/20-07/24/20. Reviewed the 400 Hall shower notebook and there were no printed reports in the notebook. She said she asked CNA B to complete the reports today (07/24/20) when the reports were requested but she did not ask her to falsify documentation. She said the internet had not gone down and no other reports had been printed and filled out by hand. In an interview on 07/23/20 at 3:30 PM CNA A said staff tried to the get the residents showers done but were not always able to get all of them done.