STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOCUSED CARE AT CEDAR BAYOU	2000 W BAKER RD BAYTOWN, TX 77521

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and, record review, the facility failed to review and revise the person-centered care plan to reflect current conditions for 2 of 10 residents (Resident #4, Resident #1) reviewed for comprehensive care plans in that; Resident #4's pressure ulcer care plan was not updated to reflect wound treatment, interventions, and wound progression. Resident #4's care plan was not updated to reflect the order to wear Geri sleeves at all times for prevention. Resident #1's care plan was not updated to reflect his current skin conditions. These failures placed residents who required updates to their care plans at risk of not having their needs met. Findings include: Resident #4 Record review of Resident #4's face sheet revealed, a [AGE] year-old-male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's Care plan dated 01/21/20 read in part, Focus: I am at risk for Skin Breakdown related to Cognitive Impairment, Decreased Sensation, Fragile Skin, Immobility, Physical Impairment, Goal: I will maintain or develop clean and intact skin throughout the review date, Interventions: All staff to be aware of resident's skin fragility. All staff to be instructed in skin protection techniques and transferring resident. Document each incident of bruising, skin tear, or other skin problems noted and tailor interventions to prevent further occurrences. Record review of Resident #4's Care plan dated 04/29/20 read in part, Focus: The resident has (Stage 4) pressure injury (Right Heel) r/t immobility 4/23/2020 N/O Santyl and Calcium Alginate Date, Goal: The resident will Pressure Ulcer will show signs of healing and remain free from infection by/through review date, Interventions: .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate . Record review of Resident #4's Weekly Wound assessment dated [DATE] revealed, a new facility acquired St III right buttock PU measuring 3 x 2 x 0.1cm, with a pink, red and yellow wound bed, moderate bloody drainage, with the surrounding skin macerated and red. On the interventions section of the assessment, Low air loss mattress and pillows for positioning/off-loading were checked. Record review of Resident #4's physician orders [REDACTED]. Record review of Resident #4's physician orders [REDACTED]. Record review of the facility's weekly Pressure Injury QAPI Log dated 05/28/20 revealed, Resident #4 had a facility acquired St IV Lt Heel PU measuring 6 x 7 x 0.2cm identified on 3/26/20, a facility acquired St IV Rt Heel PU measuring 5 x 7 x 0.3cm identified on 4/11/20, and an unstageable Lt Hip PU identified on 4/22/20 present on admission measuring 6 x 4 x UTD cm. There was no documentation of a FA St III right buttock PU or FA unstageable sacral DTI PU on the report. Further record review of the facility's weekly Pressure Injury QAPI Log dated 06/04/20 revealed, no further documentation of a St III right buttock PU or unstageable sacral wound on the report. Observation and interview on 6/09/20 at 9:51am of wound care on Resident #4 with the Wound nurse, she stated she would be completing wound care on the residents' left heel, right heel, left hip, and sacrum. When asked what stage the sacral PU wound was, she stated it was unstageable, further stating it was a DTI and the resident had a Foley catheter to allow the sacral wound to heal. When asked if the resident was lying on a low loss air mattress, she stated no, further stating he is supposed to be on an air mattress. She said all mattresses at the facility are pressure relieving mattresses, but the resident was recently placed on hospice, further stating the hospice nurse saw the resident on Friday and she requested the low loss air mattress, but she was not sure what happened. Further wound care observation and interview on 6/09/20 at 9:51 am with Resident #4 and the Wound nurse, the resident had a total of six steri strips on his left upper and lower arm, [MEDICATION NAME] dressing to his bilateral heels with his heels off-loaded using pillow support, a dressing to his right buttock, left hip/ischium, and left lateral lower extremity. The Wound nurse completed wound care on the left ischium first. He was repositioned to the right side to complete wound care to the left hip. The old dressing was removed, the dressing was not initialed or dated. The Wound nurse stated whoever completed wound care should have labeled the dressing with the date and his/her initials. The left hip PU measure approximately 4.9 x 4.6 x 0.7cm. The resident was repositioned supine and wound care was completed on the St IV right heel PU, it measured approximately 6 x 7 x 0.1cm. She stated the wound deteriorated, further stating the wound was clean before, but it changed because it now has necrotic tissue which wasn't there before. She then completed wound care to the St IV left heel PU. The wound measured approximately 6 x 7 x 0.1cm with yellow slough in the wound bed and a small amount of red drainage and necrotic tissue. Further wound care observation and interview on 6/09/20 at 9:51 am with Resident #4 and the Wound nurse revealed, wound care was completed to the residents vascular wound on the left LE, the resident was repositioned to his left side to complete wound care to the right buttock. The Wound nurse stated the right buttock wound had deteriorated further stating it was because the resident doesn't eat a lot or get out of bed. She stated the wound had a new area of necrotic tissue. The wound measured approximately 5.1 x 3.7 x UTD cm. When asked how often the Wound MD was seeing the resident, she stated the Wound MD had not been to the facility for the last two weeks because he was waiting to be tested for COVID. When asked who was performing wound measurements if the wound MD was not entering the facility, she stated she does the measurements. Further interview and observation of wound care on 6/09/20 at 9:51 am with Resident #4 with the Wound nurse, the sacral wound care was completed last, the sacral wound measured approximately 9.6 x 5.3 x 0.1cm and had multiple areas of redness and excoriations on the surrounding skin primarily to the right and left buttock, the redness extended to the back of the residents' upper thigh area. Record review of Resident #4's Physician orders [REDACTED]. Record review of the Resident #4's care plan revealed it was not updated to address the Geri Sleeves order for prevention and was not updated to address his St III Right buttock PU, Sacral DTI, and Left hip unstageable PU. Interview on 6/09/20 at 4:14 pm with the Wound nurse, when asked if the residents care plan should be revised to reflect new wounds or changes to existing wounds, she stated the last update was his heel wounds. When asked if the right buttock wound and sacral wounds should have been updated on the care plan, she stated yes, it should have been revised. Interview on 6/09/20 at 4:23 pm with the DON, when asked if Resident #4 has a new St III right buttock PU, an unstageable sacral PU, and orders to wear Geri sleeves at all times for prevention, should his care plan be revised to reflect the changes and new orders, she stated, yes, if a resident has a new wound, the care plan should be revised immediately when it is identified. Resident #1 Record review of Resident #1's face sheet revealed he was a [AGE] year old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Care Plan dated 03/24/20 revealed Resident #1 has current skin concerns: Left Buttock 0.4 x 0.2 x 0.1cm shear. Staff are to perform treatments per MD orders. Record review of Resident #1's MDS dated [DATE] revealed he had a BIMS of 3, indicating severe cognitive impairment. Record review of Resident #1's Physician order [REDACTED].[MEDICATION NAME] (a nutritional supplement) two times a day for wounds mix with 8 oz fluid of choice Start date 5/12/20 Record review of Resident #1's MAR indicated [REDACTED]. Observation on 06/03/20 at 9:40 AM revealed Resident #1 was not given [MEDICATION NAME] supplement during medication pass. In an interview on 06/09/20 at 4:11 PM Wound Nurse stated Resident #1's wound had healed. The right buttock wound should have been updated on care plan. She said she did not initiate care plans but she updated them. She said she found some issues with the care plans.

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

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	676204	A. BUILDING _____ B. WING _____	06/15/2020

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FOCUSED CARE AT CEDAR BAYOU	2000 W BAKER RD BAYTOWN, TX 77521

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) She said the policy is that care plans should be updated within 7 days. In an interview on 06/09/20 at 4:23 PM the DON stated the expectation would be for staff to immediately update the care plan. Record review of the facility's Goals and Objectives, Care Plans policy revised April 2009 read in part, .2. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly .5. Goals and objectives are reviewed and/or revised: a. When there has been a significant change in the resident's condition; b. When the desired outcome has not been achieved; c. When the resident has been readmitted to the facility from a hospital/rehabilitation stay; and d. At least quarterly .
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the services provided by the facility meet professional standards of quality for 3 of 10 residents (Resident #3, Resident #2 and Resident #4) reviewed for professional standards in that: Resident #3's heel protectors were not placed on his feet as ordered by physician. Resident #2's heel protectors were not placed on his feet as ordered by physician. Resident #4 was not wearing Geri sleeves to his bilateral arms at all times as ordered by the physician. These failures placed residents at risk of worsening health conditions, pains, psychological harm, and hospitalization . Findings include: Resident #3 Record review of Resident #3's face sheet revealed he was an [AGE] year old male that was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Record review of Resident #3's Care Plan dated 03/05/20 revealed Resident #3 had a stage 3 pressure injury to right lateral heel. Resident #3 had an arterial injury to left and right heel, and lateral malleolus related to disease process [MEDICAL CONDITION], and immobility. Staff are to administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of [REDACTED].#3's MDS dated [DATE] revealed Resident #3 had a BIMS of 12, indicating he had moderate cognitive impairment. Resident #3 had 3 venous and arterial ulcers present. Resident #3 was at risk for developing pressure ulcers/injuries. Record review of Resident #3's Physician Orders dated June 2020 revealed Bilateral Feet: Heel protectors at bedtime for offload heels Off at HS on in AM Bilateral Feet: Heel Protectors in the morning for Offload heels on in AM and Off at HS . Record review of the facility non-pressure wound list dated 06/04/20 revealed Resident #3 had a facility acquired arterial ulcer to the right lateral heal starting on 01/16/20, 2.0 x 2.5 x 0.2cm with yellow slough. Record review of the facility non-pressure wound list dated 06/04/20 revealed Resident #3 had a facility acquired arterial ulcer to the left heal starting on 02/03/20, 3.5 x 2.0 x 0.3cm with yellow slough. Observation on 06/03/20 at 10:14 AM revealed Resident #3 was sitting in a wheelchair in his bedroom. A bandage was on his bilateral foot dated 6/2. There were no heel protectors on his feet and his heels were resting on the floor. Record review of Resident #3's Weekly Wound assessment dated [DATE] revealed Resident #3 had an arterial right heel wound 2.0 x 2.5 x 0.5cm. Record review of Resident #3's Weekly Wound assessment dated [DATE] revealed Resident #3 had an arterial left heel wound 3.0 x 3.0 x 0.6cm. Observation on 06/09/29 at 12:19 PM revealed Resident #3 was sitting in his wheelchair, resident's bilateral feet wrapped, dressing dated 6/8/20. Resident legs were extended pillow under lower legs, heels resting on black wedge cushion being held up by two trashcans. Observation on 06/09/20 at 12:57 PM revealed Resident #3's heel protectors were in his closet. Observation on 6/09/20 at 2:47 pm of wound care with Resident #3 and the Wound nurse revealed, the resident's heels were off-loaded with pillows, he was wearing heel protectors bilaterally. Both heels were covered with dry [MEDICATION NAME] dressing, dated and initialed. The Wound nurse removed the old [MEDICATION NAME] wrap and dressing to the right lateral heel, the wound measured approximately 2 x 2.5 x 0.2cm, the wound bed had yellow slough, no odor or drainage noted, the surrounding skin was intact. The Site was cleansed with NS, patted dry, calcium alginate applied and covered with a clean dressing/bandage and secured with a dry [MEDICATION NAME] wrap. The Wound nurse removed the [MEDICATION NAME] dressing to the left lateral heel, the wound measured approximately 3.5 x 2 x 0.2cm, the wound bed was covered with yellow slough, no odor, or drainage noted, surrounding skin was intact. The Wound nurse cleansed the site with NS, Dakin's' solution, patted dry, Santyl and calcium alginate applied to wound bed, site covered with a clean dry dressing and secured a dry [MEDICATION NAME] bandage. There were no concerns identified during the dressing change. Observation on 6/12/20 at 8:33 am of Resident #3 revealed, the resident sitting up in bed with a wedge under his legs, he was not wearing his heel protectors. The heel protectors were sitting on a chair in the residents' room. Interview on 6/12/20 at 9:21 am with the Wound nurse, when asked if Resident #3 has an order to keep the heel protectors on during the day and off at HS, should he have the protectors on in the morning, she stated yes. When informed by the surveyor the resident was not wearing the heel protectors as ordered, she stated they were supposed to be on, but if he refused, there should be documentation in the nursing progress notes. When informed there was no documentation showing the resident refused to wear the heel protectors, she stated it should be documented. Record review of Resident #3's nursing progress notes dated 6/12/20 revealed, no documentation showing the resident refused to wear the heel protectors. In an interview on 06/09/20 at 12:52 PM CNA #1 stated Resident #3 had a wedge cushion that they put on the bed, he put his heels on that at night and during the day. She was not sure if he has any heel protectors. She said she did not work with Resident #3 all of the time and did not know if the heel protectors were in his closet. In an interview on 06/09/20 at 1:05 PM LVN #2 stated Resident #3 could put on his own heel protectors. In an interview on 06/09/20 at 1:10 PM LVN #4 stated Resident #3 had a wedge the staff put on at night while in bed to float heels, but he would sometimes moved it. She said he does kick off the wedge and she had to put it back under him in the morning. She was not sure why someone put the wedge under two trash cans that is not sanitary, she needed to get the wedge deep cleaned. She said it made no sense because his heels were touching the wedge pad and it was not relieving pressure on his heels. She was not sure about his heel protectors. In an interview on 06/09/20 at 1:19 PM the Wound Nurse said Resident #3 was supposed to have on his heel protectors while he was out of bed. She said staff put them on him to take him to the bathroom. She said staff took them off because he would put them on and try to got to the bathroom by himself and slip. She said staff used the wedge cushion when it was time to offload heels in bed. In an interview on 06/09/20 at 3:00 PM the DON stated that the orders were very confusing the way they were written so the Wound Nurse clarified them today. Resident #3 was supposed to have the heel protectors on in the A.M according to the order. The orders should be followed the way they are written, if any questions the nurse should call and clarify the order. She said restorative staff may have propped Resident #3's legs on the trashcans and that was a problem. Resident #2 Record review of Resident #2's face sheet revealed he was a [AGE] year old male that was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Record review of Resident #2's Care Plan dated 02/25/20 revealed Resident #2 was as risk for skin breakdown related to immobility, incontinence, and physical impairment. Staff are to be instructed in skin protection techniques for repositioning and transferring of resident. Record review of Resident #2's MDS dated [DATE] revealed he had a BIMS of 7, indicating he had severe cognitive impairment. Resident #2 was a risk for pressure ulcers. Record review of Resident #2's Physician Orders dated June 2020 revealed . .Bilateral Feet: Apply Heel Protectors every shift for preventive while in bed . Observation on 06/03/20 at 10:33 AM revealed Resident #2 was was lying in bed with no heel protectors on his feet. Observation on 06/09/20 at 10:42 AM revealed Resident #2 was lying in bed with pillows under his feet. He did not have heel protectors on. In an interview on 06/09/20 at 12:52 PM CNA #1, she said the nurse called Resident #2's family to come get his heel protectors because he did not want them. In an interview on 06/09/20 at 1:00 PM, LVN #3 stated Resident #2 wore the heel protectors. She said he did not have them in his room and they might be with laundry. Resident #2 was supposed to have them in bed then off when we get him up or vice versa. In an interview on 06/09/20 at 1:05 PM LVN #2 stated Resident #2 had heel protectors and the staff were supposed to put them on. In an interview on 06/09/20 at 1:10 PM LVN #4 stated Resident #2 was supposed to have on his heel protectors while in bed. In an interview on 06/09/20 at 1:19 PM the Wound Nurse stated staff put on Resident #2's heel protectors while in bed, but he did not like putting on the heel protectors. She said she had them ordered because he started getting redness to his heels. In an interview on 06/09/20 at 2:55 PM Central Supply, stated Resident #2 is supposed to have his heel protectors on at all time. She did not know for sure because she only works the hallway when someone is out. She said he did not like the heel protectors and he kicked them off. In an interview on 06/09/20 at 3:00 PM the DON stated if a resident refused the heel protectors or took them off that should be care planned. She said Resident #2 should have on heel protectors while in bed per his order. Resident #4 Record review of Resident #4's face sheet revealed, a [AGE] year-old-male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's Care plan dated 01/21/20 read in part, Focus: I am at risk for Skin Breakdown related to Cognitive Impairment, Decreased Sensation, Fragile Skin, Immobility, Physical Impairment, Goal: I will maintain or develop clean and intact skin throughout the review date, Interventions: All staff to be aware of resident's skin fragility. All staff to be instructed in skin protection techniques and transferring resident. Document each incident of bruising, skin tear, or other skin

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) problems noted and tailor interventions to prevent further occurrence. Record review of Resident #4's Physician orders dated 5/15/20 read in part, Bilateral Arms: Geri Sleeves to be on at all times for prevention. Record review of Resident #4's May 2020 TAR read in part, Bilateral Arms: Geri Sleeves to be on at all times. every shift for Preventative Monitor Q shift that they are on. Further record review of the May 2020 TAR revealed, no documentation showing the Geri sleeves were monitored that they were on for the 5/16 night shift, 5/19 night shift, 5/26 evening and night shifts, 5/27 evening shift, 5/28 day and evening shift, 5/29 evening shift, 5/30 day and evening shifts, and 5/31 day and evening shifts. Record review of Resident #4's June 2020 TAR read in part, Bilateral Arms: Geri Sleeves to be on at all times. every shift for Preventative Monitor Q shift that they are on. Further record review of the June 2020 TAR revealed, no documentation showing the Geri sleeves were monitored that they were on for the 6/1 evening shift, 6/2 day and evening shift, 6/3 day and evening shift, 6/4 day, evening, and night shifts, 6/6 day shift, and 6/7 day and evening shift. Record review of Resident #4's Care plan revealed it twas not updated to address the Geri Sleeves order. Observation on 6/09/20 at 9:51 am of Resident #4 revealed, the resident was observed without the Geri sleeves covering his arms before wound care observation until after surveyor intervention at 1:03 pm. Interview on 6/09/20 at 1:03 pm with LVN #3, when asked what the check mark on the TAR for the Geri sleeves orders indicates, she stated the check indicates the task was completed by the nurse. When asked who was responsible for ensuring the resident was wearing the Geri sleeves at all times as ordered, she stated the nurses were responsible for putting the sleeves on and the CNAs could assist the nurse. When asked if the nurse did not monitor that the sleeves were on, should the MAR indicated [REDACTED]. Observation on 6/09/20 at 1:08 PM of the Wound nurse, after surveyor intervention, the Wound nurse entered Resident #4's room to put the Geri sleeves on the resident. Record review of the facility policy Routine Skin Care not dated revealed . .1. Use appropriate pressure relieving devices for bed and chair .4. Off load / pad boney prominences, as necessary .
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 observation, 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 and worsening of pressure ulcers for 2 of 10 residents (Resident #3 and Resident #4) reviewed for pressure ulcers. The facility failed to ensure Resident #4 had a low loss air mattress after he was readmitted to the facility resulting in the development and/or worsening of multiple PU's. The treatment nurse failed to properly document the progression of a new FA St III right buttock PU and the progression of a FA unstageable sacral DTI on the weekly PU report and weekly skin assessments for Resident #4. The facility failed to ensure Resident #4's wound dressings were properly labeled with the date and initials. The facility failed to ensure Resident #3 wore heel protectors as ordered by his physician. These failures could affect residents with pressure ulcers and placed them at risk of wound deterioration, decline in health or possible hospitalization . Findings include: Resident #4 Record review of Resident #4's face sheet revealed, a [AGE] year-old-male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's Comprehensive MDS dated [DATE] revealed documentation in the section for Skin Condition showing 2 stage IV PUs, 1 unstageable PU, and 1 venous ulcer. There was no documentation of a St III PU. The Section for Skin and Ulcer/Injury Treatment documentation showing; A. Pressure reducing device for bed was checked. Record review of Resident #4's Skin/Wound progress notes dated 4/24/20 read in part, .Writer stated resident has wounds to bilateral heels, left hip, and should, s/t to right forearm, dry exudate to left anterior leg and redness to sacrum . Record review of Resident #4's Care plan dated 04/29/20 read in part, Focus: The resident has (Stage 4) pressure injury (Right Heel) r/t immobility 4/23/2020 N/O Santyl and Calcium Alginate Date, Goal: The resident Pressure Ulcer will show signs of healing and remain free from infection by/through review date, Interventions: .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate . Record review of Resident #4's physician orders [REDACTED]. Record review of Resident #4's physician orders [REDACTED]. Record review of Resident #4's Weekly Wound assessment dated [DATE] revealed a new facility acquired St III right buttock PU measuring 3 x 2 x 0.1cm, with a pink, red and yellow wound bed, moderate bloody drainage, with the surrounding skin macerated and red. On the Interventions section of the assessment, Low air loss mattress and pillows for positioning/off-loading was checked. Further record review of Resident #4's Weekly Wound Assessments dated May and June 2020 revealed no further documentation of the progression of the St III Right buttock PU and no documentation of an unstageable sacral PU. Record review of Resident #4's physician orders [REDACTED]. Record review of Resident #4's physician orders [REDACTED]. Record review of the facility's weekly Pressure Injury QAPI Log dated 05/28/20 revealed, Resident #4's facility acquired a St IV Lt Heel PU measuring 6 x 7 x 0.2cm identified on 3/26/20, a facility acquired St IV Rt Heel PU measuring 5 x 7 x 0.3cm identified on 4/11/20, and an unstageable Lt Hip PU identified on 4/22/20 present on admission measuring 6 x 4 x UTD cm. There was no documentation of a FA St III right buttock PU or FA unstageable sacral DTI PU on the report. Record review of Resident #4's physician orders [REDACTED]. Record review of the facility's weekly Pressure Injury QAPI Log dated 06/04/20 revealed, no further documentation of a St III right buttock PU or unstageable sacral wound on the report. Record review of Resident #4's Skin/Wound progress notes for the months of 5/26/20 through 06/03/20 revealed, no documentation of a new FA St III right buttock PU identified on 5/23. There was no documentation of wound care completed, measurements, or wound progression until surveyor intervention on 6/09. Further record review of Resident #4's Skin/Wound progress notes dated 6/9/20 revealed, documentation stating the sacral wound was improving. There was no further documentation showing sacral wound measurements, wound care treatment completed, or the development of an unstageable sacral DTI identified on 5/23/20. Record review of Resident #4's Care plan revealed it was not updated to address his St III Right buttock PU, Sacral DTI, and Left hip unstageable PU. Record review of Resident #4's physician orders [REDACTED]. Observation and interview on 6/09/20 at 9:51am of wound care on Resident #4 with the Wound nurse, she stated she would be completing wound care on the residents' left heel, right heel, left hip, and sacrum. When asked what stage the sacral PU wound was, she stated it was unstageable, further stating it was a DTI and the resident had a Foley catheter to allow the sacral wound to heal. She further stated the resident had steri strips to his left arm and orders are to monitor. When asked if the resident was lying on a low loss air mattress, she stated no, further stating he is supposed to be on an air mattress. She said all mattresses at the facility are pressure relieving mattresses, but the resident was recently placed on hospice, further stating the hospice nurse saw the resident on Friday and she requested the low loss air mattress, but she was not sure what happened. Further wound care observation and interview on 6/09/20 at 9:51 am with Resident #4 and the Wound nurse, the resident had a total of six steri strips on his left upper and lower arm, [MEDICATION NAME] dressing to his bilateral heels with his heels off-loaded using pillow support, a dressing to his right buttock, left hip/ischium, and left lateral lower extremity. The Wound nurse completed wound care on the left ischium first. He was repositioned to the right side to complete wound care to the left hip. The old dressing was removed, the dressing was not initialed or dated. The Wound nurse stated whoever completed wound care should have labeled the dressing with the date and his/her initials. The left hip PU measure approximately 4.9 x 4.6 x 0.7cm. The resident was repositioned supine and wound care was completed on the St IV right heel PU, it measured approximately 6 x 7 x 0.1cm. She stated the wound deteriorated, further stating the wound was clean before, but it changed because it now has necrotic tissue which wasn't there before. She then completed wound care to the St IV left heel PU. The wound measured approximately 6 x 7 x 0.1cm with yellow slough in the wound bed and a small amount of red drainage and necrotic tissue. Further wound care observation and interview on 6/09/20 at 9:51 am with Resident #4 and the Wound nurse revealed, wound care was completed to the residents vascular wound on the left LE, the resident was repositioned to his left side to complete wound care to the right buttock. The Wound nurse stated the right buttock wound had deteriorated further stating it was because the resident doesn't eat a lot or get out of bed. She stated the wound had a new area of necrotic tissue. The wound measured approximately 5.1 x 3.7 x UTD cm. When asked how often the Wound MD was seeing the resident, she stated the Wound MD had not been to the facility for the last two weeks because he was waiting to be tested for COVID. When asked who was performing wound measurements if the wound MD was not entering the facility, she stated she does the measurements. Further interview and observation of wound care on 6/09/20 at 9:51 am with Resident #4 with the Wound nurse: the sacral wound care was completed last. The sacral wound measured approximately 9.6 x 5.3 x 0.1cm and had multiple areas of redness and excoriations on the surrounding skin primarily to the right and left buttock. The redness extended to the back of the residents' upper thigh area. Interview on 6/09/20 at 10:50 am with the Wound nurse, when asked how wound measurements and wound progression was communicated to the Wound MD if he was not entering the facility, she stated after completing wound care and measurements she contacts the residents' PCP to inform him of the wound changes and if the wound deteriorated. She said he would give her new wound care orders at that time. She stated the PCP and wound MD were contacted either by phone

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	676204	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOCUSED CARE AT CEDAR BAYOU	2000 W BAKER RD BAYTOWN, TX 77521

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	(continued... from page 3) or via tele medicine if the wound deteriorates. When asked when the last time was the Wound MD saw Resident #4's wounds, she stated his last visit was on 5/07/20. She said right now the PCP was doing all wound orders and the Wound MD was updated via telephone and would agree or disagree with the PCPs orders. Interview on 6/12/20 at 10:43am with the Wound MD, when asked if the facility was contacting him regarding Resident #4's wounds and their progression, he said he could not see the resident physically, stating the resident was dying and on Hospice. He said the resident was dying but not actively dying and that was why the resident had those wounds. He said he relied on the facility to send pictures or to do some type of tele medicine stating he could not enter the facility and do rounds because he did not have his COVID test results. He said there was a gap of about 3-4 weeks and that he did not receive any information because there may have been issues at the facility related to COVID or staffing. He stated he would tell the facility if something changes don't wait until he does rounds on the day his is scheduled to come out, further stating he wants to know right away about the changes so it can be addressed before he comes out. He further stated if he needed to come out another day he would do so. Further interview on 6/12/20 at 10:43am with the Wound MD, when asked if there was another Wound MD who could have come out to manage Resident #4's wounds, he stated there were other physicians in the group, but they wanted to stick with the facility's they were already going to prevent or try to limit possible spread and cross infection. When asked if a low loss air mattress would have helped to prevent the development and/or deterioration of Resident #4's wounds, he stated it would have helped, but the biggest issue was the resident had severe [MEDICAL CONDITION] from the waist down which contributed to his wounds developing. He stated they were determining if they wanted to refer him to a specialist or stop escalation of care. He again stated the mattress would have been better than nothing. Interview on 6/09/20 at 11:04am with LVN #3, when asked what the facility's policy was regarding the use of a low loss air mattress, she stated a resident must have multiple St II PUs or a St III or higher to get an air mattress. She stated the wounds can be anywhere on the residents' body to have a low loss air mattress. Further interview on 6/09/20 at 11:04am with LVN #3, when asked what the facility's policy was regarding labeling wound dressing, she stated the dressing should have the date and initials of the nurse who completed the dressing change. Interview on 6/09/20 at 1:30 pm with the DON, when asked if Resident #4 should have been on a low loss air mattress when he had multiple St IV PUs, a St III PU right buttock PU, and an unstageable sacral PU, she stated the resident was in and out of the hospital and it did not happen because he needed an order in the system. The surveyor informed the DON, there was an order placed on 6/8, but the resident was readmitted to the facility on ,[DATE] and has not had the low loss air mattress since being readmitted . When asked if he was previously on a low loss air mattress prior to his most recent hospitalization , she stated the resident was on a low loss air mattress, further stating she had the receipt of the delivery of the air mattress. Interview on 6/09/20 at 2:29 pm with the DON, when asked why the St III right buttock PU and unstageable sacral PU were not documented on the weekly PU reports and weekly wound assessments, she stated it was a lack of communication between the weekend treatment nurse and the Wound nurse. When informed the Wound nurse is currently performing wound treatments on both wounds, but there still is no documentation showing the wound measurements or progression, she stated it should have been documented on the reports. She stated the treatment was being done because it was documented on the TAR, it just was not documented on the reports. Interview on 6/09/20 at 3:12 pm with the DON, she stated Resident #4 was previously on a low loss air mattress on 4/30 through 5/8, stating he was transferred to the hospital on 5/8. She further stated he should have had an air mattress when he was readmitted to the facility. Interview on 6/09/20 at 3:55 pm with the Wound nurse, when asked where she documented wound care and wound progression, she stated it was documented on the weekly PU report, weekly wound assessments and in the skin/wound care progress notes. When asked why the St III right buttock PU and the unstageable sacral wounds were not documented on the weekly PU reports or skin assessments for dates of 5/28/20, and 6/04/20, she stated she forgot to document the wounds. Further interview on 6/09/20 at 3:55pm with the Wound nurse, when asked if Resident #4 was on a low loss air mattress prior to his most recent hospitalization she stated yes, at some point he was on the air mattress and he should have been on the air mattress when he was readmitted . Interview on 6/12/20 at 8:52am with the Wound nurse, she stated she was trying to fix a broken system in which treatments were not consistently being done. She stated she would come in on weekends to do wound care if the weekend treatment nurse did not come in, further stating if the treatments were not done, then all her work would be undone. She stated has had to do multiple in-services on floating heels ADL care, and refusals. She stated the Wound MD has since seen Resident #4, further stating his St IV PU were reclassified to arterial wounds and that he now has additional wounds. Further interview on 6/12/20 at 8:52am with the Wound nurse, she stated she had Resident #4's St III right buttock wound and sacral DTI were not on the weekly PU report because she had them on her f drive and it did not carry over to the weekly PU report for 5/28/20 or 6/4/20. She stated she creates reports on excel then once it is all updated she must update it on the f drive or it won't carry over to the weekly report. When asked how the other wounds made it to the report for those two weeks, and why she previously stated she forgot to document these wounds, she could not state. When the surveyor requested the wound note documentation on the f drive to review, she stated she could not provide the documentation, stating she did not have access to the drive. Record review of the facility's Skin/Wound QI log dated 6/11/20 for Resident #4 revealed, two new PUs, a right hip DTI measuring 5.1 x 3.7 x UTD cm and a St III left ischium PU measuring 2.7 x 2.1 x 0.1cm; a cluster unstageable sacral PU measuring 9.6 cm x 5.3 x 0.1cm, and one improving St IV left hip PU measuring 4.9 x 4.6 x 0.7cm. The right hip DTI, St III left ischium PU, and cluster sacral wounds were not documented on previous Skin/Wound QI showing wound measurements and/or wound progression. Record review of the facility's Non-PU Skin/Wound QI log dated 6/11/20 for Resident #4 revealed, a total of eight Non-pressure wounds. The resident previously had a total of one non-pressure wound documented on the Non-pressure report dated 6/4/20. The resident had three new arterial wounds; a left lateral anterior leg venous wound measuring 2.6 x0.9 x UTD cm, a right lateral leg arterial ulcer measuring 5.1 x 2.7 x 0.1cm, a left medial planter arterial wound measuring 1.2 x 2.2 x UTDcm, and a new dry exudate right dorsal foot arterial wound measuring 1.2 x 1.2 x UTD cm. Further record review of the facility's Non-PU Skin/Wound QI log dated 6/11/20 for Resident #4 revealed, the resident's right heel and left heel PU wounds were reclassed as arterial wounds, the left heel arterial wound measured 6.2 x 7.1 0.2cm, the right heel arterial wound measured 6.1 x 6.2 x 0.3cm, an existing left cluster anterior leg [MEDICAL CONDITION] wound measuring 5.1 x 2.1 x 0.2cm, and a new arterial left great toe wound measuring 3.1 x 1.6 x 0.1cm. Interview on 6/12/20 at 2:26pm with the DON, when asked if the Wound MD was notified of Resident #4's Right Buttock and sacral wound since it was not documented on the weekly PU report, progress notes, or weekly wound report, she stated she could tell exactly when he was notified. She then stated the PCP was notified because there were orders, she could not provide any documentation showing the wound MD was notified. She stated the facility was supposed to do telehealth but for some reasons they could not do it, so the wound nurse just sent a text message. She stated they did not have to notify the Wound MD because he was only a consulting physician and the PCP provided orders for wound care. She stated as far as the documentation of the wounds, yes it should have been documented, we missed it and can only correct what's going on now. She further stated with the low loss air mattress, they just screwed up and it should have been ordered when he was readmitted . Interview on 6/15/20 at 9:29am with the DON, she stated she was not sure where the disconnect was with the wound care documentation, stating that she and the Wound nurse came into a broken system. She stated she thinks because the Wound MD was not making rounds at the facility for two weeks she felt like measurements were not being done. She stated they now have a tele health app, so the Wound MD or PCP can visualize the wounds if they can't come into the facility and the Wound MD has been educated on proper documentation, including measurements. Resident #3 Record review of Resident #3's face sheet revealed he was an [AGE] year old male that was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Record review of Resident #3's Care Plan dated 03/05/20 revealed Resident #3 had a stage 3 pressure injury to right lateral heel. Resident #3 had an arterial injury to left and right heel, and lateral malleolus related to disease process [MEDICAL CONDITION], and immobility. Staff are to administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of [REDACTED].#3's MDS dated [DATE] revealed Resident #3 had a BIMS of 12, indicating moderate cognitive impairment. Resident #3 had 3 venous and arterial ulcers present. Resident #3 was at risk for developing pressure ulcers/injuries. Record review of Resident #3's Physician order [REDACTED]. Record review of Resident #3's Weekly Wound assessment dated [DATE] revealed Resident #3 had an arterial right heel wound 2.0 x 2.5 x 0.5cm. Record review of Resident #3's Weekly Wound assessment dated [DATE] revealed Resident #3 had an arterial left heel wound 3.0 x 3.0 x 0.6cm. Record review of the facility non-pressure wound list dated 06/04/20 revealed Resident #3 had a facility acquired arterial ulcer to the right lateral heel starting on 01/16/20, 2.0 x 2.5 x 0.2cm with yellow slough. Record review of the facility non-pressure wound list dated 06/04/20 revealed Resident #3 had a facility acquired arterial ulcer to the left heel starting on 02/03/20, 3.5 x 2.0 x 0.3cm with yellow slough. Observation on 06/03/20 at 10:14 AM

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) revealed Resident #3 was sitting in a wheelchair in his bedroom. There was a bandage on his bilateral foot dated 6/2/20. There were no heel protectors on feet, and his heels were resting on the floor. Observation on 06/09/20 at 12:19 PM revealed Resident #3 was sitting in his wheelchair, his bilateral feet were wrapped annd the dressing was dated 6/8/20. Resident's legs were extended and a pillow was under his lower legs, heels resting on black wedge cushion being held up by two trashcans. Observation on 06/09/20 at 12:57 PM revealed Resident #3's heel protectors were in his closet. Observation on 6/09/20 at 2:47 pm of wound care with Resident #3 and the Wound nurse revealed, the resident's heels were off-loaded with pillows, he was wearing heel protectors bilaterally. Both heels were covered with dry [MEDICATION NAME] dressing, dated and initialed. The Wound nurse removed the old [MEDICATION NAME] wrap and dressing to the right lateral heel, the wound measured approximately 2 x 2.5 x 0.2cm, the wound bed had yellow slough, no odor or drainage noted, the surrounding skin was intact. The Site was cleansed with NS, patted dry, calcium alginate applied and covered with a clean dressing/bandage and secured with a dry [MEDICATION NAME] wrap. The Wound nurse removed the [MEDICATION NAME] dressing to the left lateral heel, the wound measured approximately 3.5 x 2 x 0.2cm, the wound bed was covered with yellow slough, no odor, or drainage noted, surrounding skin was intact. The Wound nurse cleansed the site with NS, Dakin's' solution, patted dry, Santyl and calcium alginate applied to wound bed, site covered with a clean dry dressing and secured a dry [MEDICATION NAME] bandage. Observation on 6/12/20 at 8:33 am of Resident #3 revealed, the resident sitting up in bed with a wedge under his legs, he was not wearing his heel protectors. The heel protectors were sitting on a chair in the residents' room. Interview on 6/12/20 at 9:21 am with the Wound nurse, when asked if Resident #3 had an order to keep the heel protectors on during the day and off an HS, should he have the protectors on in the morning, she stated yes. When informed by the surveyor the resident was not wearing the heel protectors as ordered, she stated they were supposed to be on, but if he refused, there should be documentation in the nursing progress notes. When informed there was no documentation showing the resident refused to wear the heel protectors, she stated it should be documented. Record review of Resident #3's nursing progress notes dated 6/12/20 revealed, no documentation showing the resident refused to wear the heel protectors. Record review of the facility's Routine Skin Care policy no date read in part, .7. All stage III & IV pressure ulcers will be placed on a specialty mattress. Record review of the facility's Skin Management System policy no date read in part, .A. Pressure Ulcers, Venous Ulcers and Arterial Ulcers, and surgical sites will be documented on the Weekly Wound Observation. Use one form per wound. Wound progress is to be documented each week with measurements and wound descriptions .2. Routine weekly checks will be completed on the Skin Observation Tool on every resident if skin is intact it will be noted as such. If a new pressure sore is noted, Weekly Wound Observation Form will be started .9. the skin report will be reviewed weekly Standard of Care Meeting. The weekly skin report is housed on your desktop .12. All dressing are to be dated and initialed upon completion .
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures for administration of all drugs, to meet the needs of each resident for 2 of 10 residents (Resident #1, Resident #3) reviewed for medications, in that: Resident #1 and #3's [MEDICATION NAME] (a nutritional supplment) was not administered as ordered by the physician. This deficient practice could place residents who receive [MEDICATION NAME] for wound healing at risk of not receiving treatments decreasing their quality of life. The findings were: Resident #1 Record review of Resident #1's face sheet revealed he was a [AGE] year old male that was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Record review of Resident #1's Care Plan dated 03/24/20 revealed Resident #1 has current skin concerns: Left Buttock 0.4 x 0.2 x 0.1 shear. Staff are to perform treatments per MD orders. Record review of Resident #1's MDS dated [DATE] revealed he had a BIMS of 3, indicating he had severe cognitive impairment. Record review of Resident #1's Physician Orders dated June 2020 revealed .[MEDICATION NAME] two times a day for wounds mix with 8 oz fluid of choice Start date 5/12/20 Observation on 06/03/20 at 9:40 AM revealed Resident #1 was not given [MEDICATION NAME] supplement during medication pass. Record review of Resident #1's MAR indicated [REDACTED]. Resident # 3 Record review of Resident #3's face sheet revealed he was an [AGE] year old male that was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Record review of Resident #3's Care Plan dated 03/05/20 revealed Resident #3 had a stage 3 pressure injury to right lateral heel. Resident #3 had an arterial injury to left and right heel, and lateral malleolus related to disease process [MEDICAL CONDITION], and immobility. Staff are to administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of [REDACTED].#3's MDS dated [DATE] revealed Resident #3 had a BIMS of 12, indicating he had moderate cognitive impairment. Record review of Resident #3's Physician Orders dated June 2020 revealed [MEDICATION NAME] Packet (Nutritional Supplements) Give 1 packet by mouth two times a day for wounds mix with 8 oz H20 . Start date 01/14/2020. Record review of Resident #3's MAR indicated [REDACTED]. Observation on 06/03/20 at 10:14 AM revealed Resident #3 was not given [MEDICATION NAME] supplement during medication pass. Record review of Resident #3's MAR indicated [REDACTED]. In an interview on 06/03/20 at 9:40 AM MA #7 stated the facility was waiting on the [MEDICATION NAME] order to come. She believed the facility ordered the [MEDICATION NAME] supplement yesterday. She said the physician had ordered that supplement for a lot of residents and the facility was using it more often. She said the [MEDICATION NAME] should come today, she checked but it was not here yet. In an interview on 06/03/20 at 1:30 PM MA# 7 stated she was not sure what happened. Orders usually comes in the afternoon she does not wait to last minute to order medication when they get low. In an interview 06/03/20 at 1:25 PM LVN #8 stated she had not given Resident #3 [MEDICATION NAME] today. She said Central Supply ordered medication and supplies on Tuesday and Thursday. She said when the medication/supplements got low it should be reordered. In an interview on 06/03/20 at 1:36 PM Central Supply stated she ordered the [MEDICATION NAME] on Monday. She did not know that there was a change in the order delivery time. She said te order used to come on Monday and the facility got it on Tuesday. She said now if she places an order on Monday then the facility gets it on Wednesday. She said the sales representative did not communicate with the facility. If the nurses get down to one box of [MEDICATION NAME] then they need to let her know so it can be reordered. In an interview on 06/03/20 at 1:45 PM the DON stated the facility ordered [MEDICATION NAME] weekly. She said she did not know the facility ran out. She said the delivery dates have changed. She said if she had known earlier that staff ran out, then she would have had one of the staff pick up some from the store. She said she was new at the facility but there were no parameter levels for OTC. When the staff get down to one box it needed to be reorder. What was happening prior was the facility would order supplies and the supplies would come the next day. She said the facility had it in the building now. Record review of the facility policy Equipment and Supplies for Administering Medications not dated revealed The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents . .4. The charge nurse is notified if supplies are inadequate or equipment fails to work properly. The charge nurse reports equipment and supply deficiencies to the Director of Nursing . Record review of the facility policy Skin Management System not dated revealed .13. Follow nutritional protocol for pressure ulcers
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 observation, interview, and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards of practice for 1 of 10 residents (Resident #4) reviewed for medical records in that; Resident #4's TARs had multiple days of missing documentation showing his Geri sleeves were monitored and on at all times every shift as ordered. This failure placed residents at risk of having incomplete and inaccurate records which could impact their treatment and health. Findings include: Record review of Resident #4's face sheet revealed, a [AGE] year-old-male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's Physician orders [REDACTED]. Record review of Resident #4's May 2020 TAR read in part, Bilateral Arms: Geri Sleeves to be on at all times. every shift for Preventative Monitor Q shift that they are on. Further record review of the May 2020 TAR revealed, no documentation showing the Geri sleeves were monitored that they were on for the 5/16-night shift, 5/19-night shift, 5/26 evening and night shifts, 5/27 evening shift, 5/28 day

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) and evening shift, 5/29 evening shift, 5/30 day and evening shifts, and 5/31 day and evening shifts. Record review of Resident #4's June 2020 TAR read in part, Bilateral Arms: Geri Sleeves to be on at all times. every shift for Preventative Monitor Q shift that they are on. Further record review of the June 2020 TAR revealed, no documentation showing the Geri sleeves were monitored that they were on for the 6/1 evening shift, 6/2 day and evening shift, 6/3 day and evening shift, 6/4-day, evening, and night shifts, 6/6-day shift, and 6/7 day and evening shift. Observation on 6/09/20 at 9:51 am of Resident #4 revealed, the resident was observed without the Geri sleeves covering his arms before wound care observation until after surveyor intervention at 1:03 pm. Interview on 6/09/20 at 1:03 pm with LVN #3, when asked what the check mark on the TAR for the Geri sleeves orders indicates, she stated the check indicates the task was completed by the nurse. When asked who is responsible for ensuring the resident is wearing the Geri sleeves at all times as ordered, she stated the nurses are responsible for putting the sleeves on and the CNAs can assist the nurse. When asked if the nurse did not monitor that the sleeves were on, should the TAR have the check mark indicating that order was completed, she stated the nurse would only put the check mark if the sleeves were on, but it should not be documented if the task was not completed. Record review of the facility's Charting and Documentation Revised July 2017 read in part, . 2. The following information is to be documented in the resident medical record: .c. Treatments or services performed .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .