STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675691	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUNTSVILLE HEALTH CARE CENTER	2628 MILAM HUNTSVILLE, TX 77340

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive, person centered care plan 1 of 6 residents reviewed for care plans. (Resident #1) The facility did not develop person-centered care plans to address Resident #1's pressure injury. This failure could place residents at risk for not receiving the proper care and services needed. Findings Included: Physician orders [REDACTED].#1 admitted on [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. An undated care plan indicated Resident #1 had the potential for pressure ulcer development to bilateral feet related to a history of ulcers. The care plan did not address the blister to the left side of his foot. A physician order [REDACTED].#1 indicated to cleanse wound/blister on te left side of the left foot with wound cleanser and apply calcium alginate and a dry dressing every day shift. A weekly skin assessment dated [DATE] and signed by the treatment nurse indicated Resident #1 had a blister to the side of his left foot. The wound was cleansed with wound cleanser, calcium alginate was applied and covered with a dry dressing. There were no further weekly wound assessments in Resident #1's medical record. A Treatment Administration Record dated May 2020 indicated on 05/18/20 a new treatment to cleanse wound on left foot with wound cleanser, apply calcium alginate and a dry dressing every day shift for wound care. The TAR was blank from 05/18/20 through 05/27/20 and not initialed to indicate the treatments were done. A progress note dated 05/18/20 at 1:04 p.m. signed by the treatment nurse indicated a treatment of [REDACTED].#1's foot. The note also indicated pressure relieving boots were applied to both of Resident #1's feet. During an interview on 06/02/20 at 3:05 p.m., the treatment nurse said she never documented the treatments in the TAR or the progress notes. She said she never had time to do documentation because she was always working other shifts or as a charge nurse. She said the wound had not increased in size although the documentation indicated the wound was bigger on 05/27/20. She said the wound care should have been done daily for Resident #1's foot. She stated she had not completed a weekly skin assessment after 05/18/20. She said the wound should have been treated daily and every resident should have a skin assessment documented weekly. During an interview on 06/02/20 at 1:55 p.m., LVN A said she was Resident #1's charge nurse on the day shift and she had never performed wound care to his left foot. She said she was not aware he had a wound on his foot. LVN A said the treatment nurse was responsible for the wound care at the facility. During an interview on 06/02/20 at 3:25 p.m., the DON said she was not able to locate a care plan for the wound to Resident #1's left foot. She said staffing had been challenging since she started at the facility, and the treatment nurse was sometimes scheduled to work the floor as a charge nurse and did not perform wound care treatments. She said on the days the treatment nurse worked on the floor as a charge nurse Resident #1's wound care should have been done by his charge nurse. She said Resident #1 wound should have been assessed and treated daily as ordered by the physician. The DON said when treatments were done it should be initialed on the Treatment Administration Record by the nurse who completed the care. A focus charting dated 05/24/20 and signed by the treatment nurse indicated Resident #1 had an area to side of left foot. The note did not indicate wound measurements, description or treatments done. A skilled wound care provider communication log dated 05/27/20 written by the wound care physician indicated Resident #1 had a deep tissue pressure injury to his left lateral foot. The wound measurements were 6.2 cm x 5.9 cm. New orders were written to cleanse the wound on Resident #1's left foot (outside) with wound cleanser, apply [MEDICATION NAME], calcium alginate patch, and cover with a dry dressing every day shift. An undated facility policy and procedure titled Wound Management Process, revealed in part .The Treatment Nurse will ensure the following information is included in weekly wound observation: 1) Description of wound, 2) Tolerance of dressing changes; ie pain management needs, 3) Nutrition interventions, 4) Preventive/Protective equipment; ie specialty mattress, boots, etc., 5) Co morbidities or obstacles to wound healing, 6) Effectiveness of treatment, 7) Updates care plan with any changes in goals, interventions, or problems as indicated .
F 0659 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide services in accordance with each resident's written plan of care for 1 of 6 residents reviewed for physician orders. (Resident #1) The facility did not ensure Resident #1 wound care treatments as ordered by the physician. This failure could place residents with wounds at risk for not receiving appropriate care and services. Findings Included: Physician orders [REDACTED].#1 admitted on [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. A physician order [REDACTED].#1 indicated to cleanse wound with wound cleanser and apply calcium alginate and a dry dressing every day shift. A Treatment Administration Record dated May 2020 indicated on 05/18/20 a new treatment to cleanse wound to left foot with wound cleanser, apply calcium alginate and a dry dressing every day shift for wound care. The TAR was blank from 05/18/20 through 05/27/20 and was not initialed by a nurse to indicate the treatments were done. A weekly skin assessment dated [DATE] and signed by the Treatment Nurse indicated Resident #1 had a 3 centimeter blister to the side of his left foot. The wound was cleansed with wound cleanser, calcium alginate was applied and covered with a dry dressing. There were no further weekly wound assessments in Resident #1's medical record. A progress note dated 05/18/20 at 1:04 p.m. signed by the treatment nurse. indicated a treatment of [REDACTED].#1's foot. The note also indicated pressure relieving boots were applied to both of Resident #1's feet. An undated care plan indicated Resident #1 had the potential for pressure ulcer development to bilateral feet related to history of ulcers. The care plan did not address the blister to the left side of his foot. A focus charting dated 05/24/20 and signed by the treatment nurse indicated Resident #1 had an area to side of left foot. The note did not indicate wound measurements, a wound description or treatments. A skilled wound care provider communication log dated 05/27/20 written by the wound care physician indicated Resident #1 had a deep tissue pressure injury to his left lateral foot. The wound measurements were 6.2 cm x 5.9 cm. New orders were written: to cleanse the wound on Resident #1's left foot (outside) with wound cleanser, apply [MEDICATION NAME], calcium alginate patch, and cover with a dry dressing every day shift. During an interview on 06/02/20 at 1:55 p.m., LVN A said she was Resident #1's charge nurse on the day shift and she had never performed wound care to his left foot. She said she was not aware he had a wound on his foot. LVN A said the treatment nurse was responsible for the wound care treatments. During an interview on 06/02/20 at 3:05 p.m., the treatment nurse said she never documented the treatments in the TAR or the progress notes. She said she never had time to do documentation because she was always working other shifts or as a charge nurse. She said the wound had not increased in size although the documentation indicated the wound was bigger on 05/27/20. She said the wound care should have been done daily for Resident #1's foot. She stated she had not completed a weekly skin assessment after 05/18/20. She said the wound should have been treated daily and every resident should have a skin assessment documented weekly. During an interview on 06/02/20 at 3:25 p.m., the DON said she was not able to locate a care plan for the wound to Resident #1's left foot. She said staffing had been challenging since she

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675691	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUNTSVILLE HEALTH CARE CENTER	**2628 MILAM HUNTSVILLE, TX 77340**

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 0659 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) started at the facility, and the treatment nurse was sometimes scheduled to work the floor as a charge nurse and did not perform wound care treatments. She said on the days the treatment nurse worked on the floor as a charge nurse Resident #1's wound care should have been done by his charge nurse. She said Resident #1 wound should have been assessed and treated daily as ordered by the physician. The DON said when the treatments were done it should be initialed on the Treatment Administration Record by the nurse who completed the care. An undated facility policy and procedure titled Wound Management Process, revealed in part .The Treatment Nurse will ensure the following information is included in weekly wound observation: 1) Description of wound, 2) Tolerance of dressing changes; ie pain management needs, 3) Nutrition interventions, 4) Preventive/Protective equipment; ie specialty mattress, boots, etc., 5) Co morbidities or obstacles to wound healing, 6) Effectiveness of treatment, 7) Updates care plan with any changes in goals, interventions, or problems as indicated .
F 0686 **Level of harm -** Minimal harm or potential for 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 ensure appropriate treatment and services consistent with professional standards of practice to promote healing of a pressure injury was provided for 1 of 6 residents reviewed for pressure injury. (Resident #1) The facility did not provide wound treatments for Resident #1's pressure injury for 9 days. This failure could place residents with pressure injuries at risk for wound worsening and decline. Findings Included: Physician orders [REDACTED].#1 admitted on [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. A weekly skin assessment dated [DATE] and signed by the Treatment Nurse indicated Resident #1 had a blister to the side of his left foot. The wound was cleansed with wound cleanser, calcium alginate was applied and covered with a dry dressing. There were no further weekly wound assessments in Resident #1's medical record. A physician order [REDACTED].#1 indicated to cleanse wound with wound cleanser and apply calcium alginate and a dry dressing every day shift. A Treatment Administration Record dated May 2020 indicated on 05/18/20 a new treatment to cleanse wound left foot with wound cleanser, apply calcium alginate and a dry dressing every day shift for wound care. The TAR was blank from 05/18/20 through 05/27/20 and was not initialed by a nurse to indicate the treatments were done. A progress note dated 05/18/20 at 1:04 p.m. signed by the treatment nurse. indicated a treatment of [REDACTED].#1's foot. The note also indicated pressure relieving boots were applied to both of Resident #1's feet. An undated care plan indicated Resident #1 had the potential for pressure ulcer development to bilateral feet related to history of ulcers. The care plan did not address the blister to the left side of his foot found on 05/18/20. A focus charting dated 05/24/20 and signed by the treatment nurse indicated Resident #1 had an area to side of left foot. The note did not indicate wound measurements, a wound description or treatments. A skilled wound care provider communication log dated 05/27/20 written by the wound care physician indicated Resident #1 had a deep tissue pressure injury to his left lateral foot. The wound measurements were 6.2 cm x 5.9 cm. New orders were written to cleanse the wound on Resident #1's left foot (outside) with wound cleanser, apply [MEDICATION NAME], calcium alginate patch, and cover with a dry dressing every day shift. A dietary consult note dated 05/28/20 and signed by the dietician indicated Resident #1 was reviewed for deep tissue injury per skin report. Dietician made recommendations for supplemental shake if less than 50% eaten at meals and weekly weights. During an interview on 06/02/20 at 1:55 p.m., LVN A said was Resident #1's charge nurse on the day shift and she had never performed wound care to his left foot. She said she was not aware he had a wound on his foot. LVN A said the treatment nurse did the wound care treatments. During an interview on 06/02/20 at 3:05 p.m., the treatment nurse said she never documented the treatments in the TAR or the progress notes. She said she never had time to do documentation because she was always working other shifts or as a charge nurse. She said the wound had not increased in size although the documentation indicated the wound was bigger on 05/27/20. She said the wound care should have been done daily for Resident #1's foot. She stated she had not completed a weekly skin assessment after 05/18/20. She said the wound should have been treated daily and every resident should have a skin assessment documented weekly. During an interview on 06/02/20 at 3:25 p.m., the DON said she was not able to locate a care plan for the wound to Resident #1's left foot. She said staffing had been challenging since she started at the facility, and the treatment nurse was sometimes scheduled to work the floor as a charge nurse and did not perform wound care. She said on the days the treatment nurse worked on the floor as a charge nurse Resident #1's wound care should have been done by his charge nurse. She said Resident #1 wound should have been assessed and treated daily as ordered by the physician. The DON said when treatments were done it should be initialed on the Treatment Administration Record by the nurse who completed the care. An undated facility policy and procedure titled Wound Management Process, revealed in part .The Treatment Nurse will ensure the following information is included in weekly wound observation: 1) Description of wound, 2) Tolerance of dressing changes; ie pain management needs, 3) Nutrition interventions, 4) Preventive/Protective equipment; ie specialty mattress, boots, etc., 5) Co morbidities or obstacles to wound healing, 6) Effectiveness of treatment, 7) Updates care plan with any changes in goals, interventions, or problems as indicated .