STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675176	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCCULLOUGH HALL NURSING CENTER INC	603 S W 24TH ST SAN ANTONIO, TX 78207

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observations, interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs, for 2 of 3 Residents (#22 and #39) reviewed for care plan development and implementations, in that: 1) Resident #22's care plan did not address her use of compression sleeves to her forearms as ordered by her physician. 2) Resident #39's care plan did not address her risk for wandering. These deficient practices could place residents with compression stockings and residents who wander at risk for physical and psychosocial injuries and place them at risk of not receiving the therapeutic effects of the physician's intended care. The findings were: 1) Record review of Resident #22's face sheet revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #22's physician orders [REDACTED]. Off during shower. Record review of Resident #22's care plan, last revised 12/26/2019, revealed a focus for I have actual impairment to skin integrity of extremities and face. Further review of the care plan revealed Resident #22's compression sleeves to bilateral forearms were not addressed. Observation on 3/4/2020 at 11:15 AM revealed Resident # 22 was sitting in her chair in her room. Further observation revealed she did not have on the compression sleeves to her bilateral forearms. During an interview on 3/4/2020 at 11:18 AM, with RN H, confirmed Resident #22 had no compression sleeves on her bilateral forearms. Interview on 3/5/2020 at 2:50 PM with the DON revealed a care plan should be developed and implemented to support the physician's orders [REDACTED].#39's face sheet revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #39's MDS quarterly assessment dated [DATE], revealed a BIMS score of 13 (cognitively intact) with no history of wandering. Record review of Resident #39's wandering risk assessments dated 1/28/2019, 7/9/2019, 10/15/2019, 12/1/2019, and 1/29/2020 revealed Resident # 39 was at medium risk for wandering. Record review of Resident #39's care plan last revised on 11/11/2019 did not address wandering. In an interview on 3/5/2020 at 11:10 AM RN A stated Resident #39 had a history of [REDACTED].# 39 had left the facility in the past. In an interview on 3/5/2020 at 2:11 PM, CNA G revealed Resident #39 leaves the facility, unsupervised, daily for breakfast and lunch in the adjoining building. In an interview on 3/5/2020 at 2:18 PM Resident #39 stated she ate breakfast and lunch daily in the convent's main dining room outside of the facility, unsupervised. Observation on 3/5/2020 at 2:30 PM of the facility's dining room exit, revealed an unlocked exit leading to the adjoining buildings. Further observation revealed the walk to the convent dining room passed several unlocked unsupervised exits providing egress out to the public. In an interview on 3/5/2020 at 2:50 PM the DON stated Resident # 39 ate breakfast and lunch daily in the main dining room outside of the facility. In an interview on 3/5/2020 at 5:10 PM, the Administrator, confirmed Resident #39 left the facility, unsupervised, daily for breakfast and lunch in the adjoining building, passing several unlocked unsupervised exits providing egress out to the public. In an interview on 3/6/2020 at 11:30 AM the Administrator stated the policy for developing and implementing care plans was to follow HHSC guidelines.
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, interviews and record reviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for 2 of 2 residents (Resident #22 and #46), reviewed in that: 1. Resident #22 did not receive her bilateral compression sleeves to her forearms as ordered by her physician. 2. Resident #46 did not receive her bilateral heel protectors, while in bed as ordered by the physician. These deficient practices could place residents with compression stockings and residents with orders for heel protectors at risk of not receiving necessary treatment services. The findings were: 1. Record review of Resident #22's face sheet revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #22's physician orders [REDACTED]. Off during shower. Record review of Resident #22's current care plan, last revised 12/26/2020, revealed a focus for I have actual impairment to skin integrity of extremities and face. Further review revealed Resident # 22's compression sleeves were not addressed. Observation on 3/4/2020 at 11:15 AM revealed Resident # 22 was sitting in her room. Further observation revealed she did not have on compression sleeves to her bilateral forearms. During an interview on 3/4/2020 at 11:18 AM, with RN H, confirmed Resident #22 had no compression sleeves to her bilateral forearms. During an interview on 3/5/2020 at 2:30 PM, the DON, confirmed Resident #22 did not have bilateral compression sleeves to her forearms and staff should be following the physician's orders [REDACTED].#22's bilateral compression sleeves to her forearms should have been applied as ordered. 2. Record review of resident #46's face sheet revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #46's physicians' orders revealed an order dated 12/2/2020, to Apply heel protectors bilaterally while in bed or float heels (elevate heels). Record review of Resident #46's care plan, dated [DATE], revealed The resident has potential for pressure ulcer development related to physical immobility. Apply heel protectors bilaterally while in bed or float heels. Observation on 3/4/2020 at 4:21 PM revealed Resident #46 was in her bedroom lying in her bed without heel protectors or floated heels. During an interview on 3/4/2020 at 4:25 PM with RN A, confirmed Resident #46 was in her bedroom lying in her bed without heel protectors or floated heels. During an interview on 3/5/2020 at 2:30 PM, with the DON, confirmed Resident #46 was in her bedroom lying in her bed without heel protectors or floated heels. The DON stated the facility's policy was to follow the physicians' orders. During an interview on 3/5/2020 at 5:23 PM the Administrator stated Resident #46's heels should have been floated as ordered. During an interview on 3/6/2020 at 11:30 AM, with the Administrator stated the policy for quality of care is to follow HHSC guidelines.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision, for 1 of 1 residents, (#39), reviewed for safety and supervision, in that: Resident #39 was at risk for wandering and there were no interventions in place. This deficient practice could affect residents that wander and could result in elopement and injury. The findings

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) were: Record review of Resident #39's face sheet revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #39's wandering risk assessments dated 1/28/2019, 7/9/2019, 10/15/2019, 12/1/2019, and 1/29/2020 revealed Resident # 39 was a medium risk for wandering. Record review of Resident #39's MDS quarterly assessment dated [DATE], revealed a BIMS score of 13 with no history of wandering. Record review of Resident #39's current care plan, last revised on 11/11/2019, did not reveal a focus or interventions for wandering. Record review of Resident #39's care plan revealed a focus, dated 4/30/2018, that read, I will go to Regan Hall dining room to eat. I have my breakfast and lunch at Regan dining room.; I know I walk a long distance when I go to Regan Hall, I will take a break if I need to; I will make sure I get rest between my room to Regan dining room. Interview on 3/5/2020 at 11:10 AM with RN A, confirmed Resident #39 was discovered wandering off the home and Resident #39 was discovered by campus police, wandering down the street and arrived at a local fast food restaurant. Interview on 3/5/2020 at 2:11 PM, with CNA G, confirmed Resident #39 leaves the facility, unsupervised, daily for breakfast and lunch in the adjoining building. Interview on 3/5/2020 at 2:18 PM with Resident #39 confirmed she ate breakfast and lunch daily in the convent's main dining room outside of the facility, unsupervised. Observation on 3/5/2020 at 2:30 PM of the facility's dining room exit, revealed an unlocked exit leading to the adjoining buildings. Further observation revealed the walk to the dining room passed several unlocked unsupervised exits providing egress out to the public. Interview on 3/5/2020 at 2:50 PM with the DON, confirmed she eats breakfast and lunch daily in the convents main dining room outside of the facility, unsupervised. During an interview on 3/5/2020 at 5:10 PM the Administrator, confirmed Resident #39 left the facility, unsupervised, daily for breakfast and lunch in the adjoining building, passing several unlocked unsupervised exits providing egress out to the public. During an interview on 3/6/2020 at 11:30 AM, with the Administrator confirmed the policy for safety an supervision was to follow HHSC guidelines.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary for 1 of 1 resident (Resident #7), in that: Resident #7 did not have an order for [REDACTED].# 7's face sheet dated 3/6/2020 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 7's consolidated physician orders [REDACTED]. Review of Resident # 7's Admission MDS dated [DATE] revealed she had an indwelling catheter. Review of Resident #7's Quarterly MDS dated [DATE] revealed she was cognitively moderately impaired and and had an indwelling catheter. Review of Resident # 7's Care Plan initiated on 3/14/2019 read I have an Indwelling Catheter due to obstruct [MEDICAL CONDITION] and I have an indwelling catheter with 16 French, position catheter bag and tubing below the level of the bladder. Observation on 03/03/2020 at 1:11 PM revealed Resident #7 was sitting in her wheelchair in her room. Further observation revealed she had an indwelling catheter in a privacy bag. Interview on 03/05/2020 at 5:58 PM with the DON confirmed Resident # 7 did not have a physician's orders [REDACTED]. The DON stated they did not have a policy on orders for an indwelling catheter.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 2 residents (Resident #27) reviewed for oxygen orders in that: Resident #27's physician's orders [REDACTED]. This deficient practice could affect residents who used oxygen and could result in residents receiving incorrect or inadequate oxygen support and could result in a decline in health. The findings were: Review of a face sheet dated 2/11/20 for Resident #27 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #27's consolidated Physician order [REDACTED].#27 was receiving oxygen at 5 LPM via nasal cannula. In an interview on 3/05/20 at 2:48 PM RN A stated Resident # 27 received oxygen on a daily basis and indicated the amount being delivered should not exceed 3 LPM which was the facility's standing order for oxygen. RN confirmed Resident #27 physician's orders [REDACTED]. RN A stated orders for oxygen should include the amount of oxygen to be delivered. In an interview on 3/05/20 at 3:09 PM the DON stated she would expect a physician's orders [REDACTED]. Review of a facility policy, titled Oxygen Administration undated, revealed Procedure: 1. check physician's orders [REDACTED].
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PRN orders for [MEDICAL CONDITION] drugs were limited to 14 days and if the attending physician or prescribing practitioner believed that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order for 1 of 4 residents (Resident #27) reviewed for antipsychotic medication, in that: The facility administered an anti-anxiety medication, [MEDICATION NAME] PRN (as needed) to Resident #27, for more than 14 days, without a rationale. This failure could place residents with orders for PRN [MEDICAL CONDITION] medications at risk of receiving unnecessary medications. The findings were: Review of Resident # 27's face sheet dated 2/11/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident # 27's physician's orders [REDACTED]. Review of Resident # 27's MAR for February 2020 and (NAME)2020 revealed Resident # 27 received [MEDICATION NAME] 8 times during the month of February on 2/7/20, 2/12/20, 2/18/20, 2/19/20, 2/20/20, 2/22/20, 2/23/20 and 2/25/20 and 1 time in the month of (NAME)on 3/5/20. Review of a pharmacy Consultant Report dated 2/11/20 for Resident # 27 read Resident #27 had a PRN order for an anxiolytic, without a stop date: [MEDICATION NAME] ([MEDICATION NAME]) 0.5 mg every 6 hours PRN anxiety with the recommendation to discontinue PRN [MEDICATION NAME]. Further review revealed, a note that read, current regulations require that the prescriber document the indication for use (Anxiety), the intended duration of therapy and the rationale for the extended time period (Hospice). Further review of the document revealed the physician had declined the recommendation and did not wish to implement any changes and indicated, Patient doing well with this med. The document was signed by the physician on 2/13/20. Interview with the DON on 3/5/20 at 6:15 PM confirmed Resident # 27 had a PRN order for [MEDICATION NAME] which extended past the required 14 days and did not have a rationale for continued use of the medication past the 14 days. The DON stated the physician had restarted the medication without assessing the resident in the facility. Review of a facility's policy [MEDICAL CONDITION] Medication Use dated 12/1/07 and last revised on 11/28/16 revealed 1. Facility should comply with the Psychopharmacologic Dosage Guidelines created by the Centers for Medicare and Medicaid Services (CMS), the State Operations Manual, and all other applicable law relating to the use of psychopharmacologic medications including gradual dose reductions. 5. PRN orders for [MEDICAL CONDITION] drugs should be limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. 6. PRN orders for anti-psychotic drugs should be limited to 14 days and should not be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration

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F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) the preferences of each resident for 3 of 17 residents (#16, #41 and #45) in that: 1. Resident #16 did not have an order for [REDACTED]. Resident #41 did not have an order for [REDACTED].# 41 received regular meat instead of pureed as ordered. 3. Resident #45 did not have an order for [REDACTED].#16, #41 and #45's meal tickets read small portions. 1. Review of Reside #16's face sheet dated 03/06/2020 revealed she was admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #16's Diet Type report dated 3/4/2020 revealed she had a regular diet as tolerated and was on a mechanical soft diet per her own preference. Review of Resident #16's consolidated physician's orders [REDACTED]. Further review revealed no order for small portions. Review of Resident #16's Quarterly MDS dated [DATE] revealed a BIMS of 15/15 (cognitively intact), ate independently and had no weight loss. Review of Resident #16's care plan dated 12/25/2019 revealed mechanical soft diet, I would like to keep my weight stable. Further review revealed no documentation for small portions. 2. Review of Resident #41's face sheet dated 03/06/2020 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #41's consolidated orders for (NAME)2020 revealed she had an order for [REDACTED]. Review of Resident #41's Quarterly MDS dated [DATE] revealed a BIMS of 09/15 (moderately cognitively intact), required supervision for eating (set-up only) and no weight loss. Review of Resident #41's care plan dated 1/20/2020 revealed small portions during meals. Observation on 3/4/2020 at 12:47 PM in the main dining room revealed Resident #41 had regular meat on her plate. In an interview on 3/04/20 at 12:48 PM Resident #41 stated she received pureed meat. In an interview on 3/04/20 at 12:48 PM, CNA C confirmed Resident #41 had a regular meat for lunch. In an interview on 3/04/20 at 12:50 PM LVN D confirmed Resident #41 had a regular meat for lunch and should have received puree. 3. Review of Resident #45's face sheet dated on 3/4/2020 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #45's consolidated orders for (NAME)2020 revealed orders for mechanical soft texture, regular consistency, resident to have 1/2 portion desserts; 2 vegetables (no starch, no corn, no pasta, no rice). Further review revealed no order for small portions. Review of Resident #45's Quarterly MDS dated [DATE] revealed a BIMS of 06/15 (severely cognitively impaired), required extensive assistance for eating (1 person assist) and no weight loss. Review of Resident #45's Care Plan dated (no date) and the Diet Type Report (3/4/2020) revealed she was on regular diet as tolerated, please provide a scoop plate positioned with opening on right side, resident to have 1/2 portion desserts and 2 vegetables. In an interview on 3/04/20 at 12:24 PM Dietary Aide B stated she was told to use 1/2 (2 ounces) of the regular scoop size for residents with small portions. In an interview on 03/04/20 at 12:37 PM the Administrator stated the dietician consultant ordered small portions for Residents #16, #41 and #45. In an interview on 03/04/20 at 12:38 PM with FSD (Food Service Director) confirmed Residents #16, #41 and #45 had small portions and did not have orders for small portions. Review of the policy Small Portions dated 12/15/2016 revealed Small Portions may be requested by residents who have small appetite or when regular portions seem overwhelming and must be physician ordered.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview and record review the facility failed to ensure the menu was reviewed by the facility's qualified nutrition professional for nutritional adequacy for 1 of 1 kitchen in that: The kitchen daily spread sheet for Wednesday Day 11 did not have a scoop size for starches. This deficient practice could affect resident who received food from the kitchen and could result in residents not receiving appropriate serving size. The findings were: Observation on 3/4/2020 at 12:23 PM of the kitchen area serving line revealed dietary aide B placed a 2 and 4 ounce scoop in the rice/potatoes tray in the serving line. Review of the dietary daily spreadsheet dated Wednesday Day 11 (3/4/2020) revealed no scoop sizes were documented for the starches. In an interview on 3/04/20 at 12:24 PM Dietary Aide B confirmed that no starch scoop size was documented on the dietary daily spreadsheet dated Wednesday Day 11. In an interview on 3/04/20 at 12:37 PM the kitchen FSD (Food Service Director) confirmed there were no starch scoop size indicated on the dietary daily spreadsheet dated Wednesday Day 11. Further interview with the FSD revealed there was no policy for menus.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food that accommodated resident preferences for 1 of 17 Residents (Resident #50) reviewed for meals, in that: Resident #50's was served potatoes for lunch even though it was listed as a dislike. This deficient practice could affect residents who received meals from the kitchen and could result in resident preferences not being met. The findings were: Review of Resident #50's face sheet dated 03/06/2020 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #50's Quarterly MDS dated [DATE] revealed her cognitive pattern was severely impaired, she was totally dependent for meals (required a one person assist). Review of Resident #50's consolidated orders for (NAME)2020 revealed an order for [REDACTED].# 50 sat in a high back wheelchair and was being feed by staff, small portions, to include mashed potatoes. Interview on 03/03/20 at 12:34 PM with CNA C confirmed that she was feeding Resident #50 potatoes and the meal ticket read disliked potatoes. Review of the facility's policy on Resident Food Preferences dated July 2017 revealed 2.When possible, staff will interview the resident directly to determine current food preference based on history and life patterns related to food and mealtimes.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, interviews and record reviews the facility failed to ensure the facility distributed and served food in accordance with professional standards for food service safety for 1 of 1 kitchen in that: 1. Dietary Aide E did not completely cover her hair while in the kitchenette area. 2. CNA F did not wear a hair net when going in and out of the kitchen during serving time. This defecient practice could place residents who received meals form the kitchen at risk for food-borne illnesses. The findings were: 1. Observation on 3/03/2020 at 12:03 PM in the kitchenette area revealed Dietary Aide E was plating food from the hot steamer. Further observation revealed Dietary Aide E's hair net did not fully cover the back of her hair. In an interview on 3/03/2020 at 12:08 PM Dietary Aide E confirmed her hair net did not fully cover the back of her hair. 2. Observation on 3/04/2020 at 11:57 PM in the kitchenette area revealed CNA F walked in and out of the kitchenette without a hairnet as food was being set-up and plated. In an interview on 3/04/2020 at 11:58 AM CNA F confirmed she walked in and out of the kitchen area without a hair net. Review of the facility's policy for Personal Hygiene/Safety/Food Handling dated 1/30/2020 read Head Covering Worn, a. wear a clean hat or other hair restraint. Hair must be appropriately restrained or completely covered.