STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN WINDS LIVING & REHABILITATION	**3301 FM 3009 SCHERTZ, TX 78154**

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to treat the resident with respect and dignity for 1 of 3 residents observed (Resident #60) during incontinent/peri care and catheter care in that: CNA C and CNA D during incontinent/ peri care and catheter care left Resident #60 exposed in the bed while they went to wash their hands. This failure could place residents at risk of psychosocial harm, decreased sense of self-worth and depression as a result of feeling uncomfortable while providing incontinent/peri care and catheter care. The findings were: Record review of Resident #60's Face Sheet, dated 03/13/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #60's Admission MDS dated [DATE], revealed Resident #60 was moderately cognitively impaired for daily decision-making skills. Further review of the Admission MDS revealed Resident #60 was always incontinent of bowel and had an indwelling catheter. Observation on 03/13/2020 at 9:15 a.m. during incontinent/ peri care and catheter care for Resident #60 revealed CNA C and D left Resident # 60 in bed in a high position and exposing the genitals while CNA C and CNA D went to wash their hands. Interview on 03/13/2020 at 9:16 am, CNA C and CNA D (assisting CNA C) confirmed they had walked away and left Resident #60 exposed revealing his genitals and the bed in high position while they went to wash their hands. Interview on 03/13/2020 10:01 a.m. with Resident #60, revealed he felt embarrassed and naked when he was left up in the air and exposed. Review of the facility document titled Quality of Life-Dignity, date Revision 10/2009. Stated in part: .Each Resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality 1. The resident will be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth 10. Staff shall promote and protect resident privacy, including bodily privacy during assistance with personal care
F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on observation and interview, the facility failed to provide a private space for residents' monthly council meetings for 9 of 9 residents reviewed for resident council in that: The facility did not provide a private space for resident council meetings. This failure could place residents who attended resident council meetings at risk of decreased confidence with administration, decreased resident rights and a decreased quality of life. The findings were: Observations on 3/11/2020 from 2:00 p.m. to 3:00 p.m. during the resident council meeting revealed the meeting was held in a common area where activities took place. Further observation revealed there was 1 closed door with a small window on one side and 1 open area on the opposite side that led directly into the nurse's station. Several Staff and 1 resident, who were not participating in the resident council meeting, were observed walking through the activity area both from the closed door and from the nurse's station on 10 separate occasions during the resident council meeting. During an interview with Activity Director E on 3/11/2020 at 3:49 p.m. revealed an average of 15 to 20 residents had attended the resident council meetings on a regular basis. Activity Director E stated she was aware of the lack of privacy during the resident council meetings in the space that was provided to the residents. Activity Director E further stated that resident council meetings used to be held in the conference room, but it could only accommodate 5 to 7 residents.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessments accurately reflected the resident's status for 1 of 3 residents (Resident #22) reviewed for PASRR assessments in that: Resident #22's Annual MDS did not indicate the resident was PASARR positive. This deficient practice could place PASRR residents at risk of not receiving needed care and services due to inaccurate assessments. The findings were: Review of Resident #22's face sheet dated 3/13/20, revealed an admission date of [DATE] and re-admission date of [DATE], with [DIAGNOSES REDACTED]. Review of Resident #22's PASRR Evaluation dated 7/16/19 revealed he was positive due to mental illness. Review of Resident #22's Admission MDS dated [DATE] revealed a BIMS score of 10 which indicated the resident was cognitively intact for daily decision-making skills. Further review of the Admission MDS revealed the PASARR positive status was marked No. Review of Resident #22's Care Plan, undated, revealed a focus that Resident #22 had been identified as PASRR positive due to mental illness related to a [DIAGNOSES REDACTED].#22 was PASARR positive. Record review of the document titled Resident Assessment Instrument, revision date 10/2010, revealed in part .3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity .4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning .
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included measurable objectives to meet a resident's medical and nursing needs for 1 of 18 residents (Resident #59) whose care plan was reviewed, in that: Resident #59 did not have a baseline care plan since admission. This deficient practice could place residents who required medical and nursing care at risk for injury or improper care due to inaccurate care plans. The findings were: Record review of Resident 59's face sheet, dated 3/11/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #59's Admission MDS, dated [DATE], revealed a BIMS score of 14 which indicated the resident was cognitively intact for daily decision-making skills. Record review of Resident #59's care plan revealed that no baseline care-plan was developed. Interview on 3/12/2020 at 10:30 a.m. with MDS Coordinator G confirmed the initial baseline care plan was not developed for Resident #59. Record review of the facility policy titled Resident Assessment Instrument, revised (10/2010), revealed in part .A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission .conduct timely resident assessments and reviews according to the following schedule: a. Within fourteen (14) days of the resident's admission to the facility; b. When there has been a significant change in the resident's condition; c. At least quarterly, and d. Once every twelve (12)

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) months .4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning .
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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives to meet a resident's medical and nursing needs for 1 of 18 residents (Resident #27) whose care plan was reviewed, in that: Resident #27's Comprehensive Care Plan was not developed since admission. This deficient practice could place residents who required medical and nursing care at risk for injury or improper care due to inaccurate care plans. The findings were: Record review of Resident #27's face sheet, dated 03/13/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #27's Admission MDS, dated [DATE], revealed a BIMS score of 14, which indicated the resident was cognitively intact. Further review revealed Resident #27 required extensive assistance from one staff member for transfers, to include moving to and from the bed, chair, wheelchair, standing position and dressing. Record review of Resident #27's Care Plan revealed there was no Comprehensive Care Plan available. Interview on 03/13/20 02:30 p.m. with MDS Coordinator G revealed the Comprehensive Care Plan for Resident #27 was not completed and should have done on 01/29/20. MDS Coordinator C stated they had a care plan meeting on 03/11/20. Record review of the facility policy titled Resident Assessment Instrument (revised 10/2010) revealed in part .A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission .conduct timely resident assessments and reviews according to the following schedule: a. Within fourteen (14) days of the resident's admission to the facility; b. When there has been a significant change in the resident's condition; c. At least quarterly, and d. Once every twelve (12) months .4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highst practicable level of functioning .
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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 review, the facility failed to ensure the resident environment remained as free from accident and hazards as was possible for 13 of 29 residents (Residents #5, 11, 14, 15, 19, 21, 28, 41, 42, 43, 55, 56 and 72), in that: 1. The hot water in the 200 Hall was not being regulated, which resulted in hot water temperatures that ranged from 130 degrees Fahrenheit (F) to 153.6 degrees F. (Hot water for resident use must be reliably controlled to not exceed 110 degrees F. and not less than 100 degrees F). 2. Thirteen residents (Residents #5, 11, 14, 15, 19, 21, 28, 41, 42, 43, 55, 56 and 72) in the 200 Hall had [DIAGNOSES REDACTED]. In addition, 7 out of the 13 residents (Residents # 5, 10, 29, 42, 56, 69, 72) had [DIAGNOSES REDACTED]. 3. The facility had been aware of issues with the regulation of hot water temperatures above 110 degrees F. on the 200 Hall, since (NAME)04, 2019 These failures resulted in an Immediate Jeopardy (IJ) situation identified on 03/10/20. While the IJ was removed on 03/12/20, the facility remained out of compliance at a level of potential harm with a scope of a pattern until the water heater and regulator was repaired and all staff were in-serviced. These deficient practices can place residents with altered mental status or lack of sensation at risk for burns. The findings were: Record review of Resident's in the 200 Hall medical records revealed 13 residents (Residents #5, 11, 14, 15, 19, 21, 28, 41, 42, 43, 55,56 and 72) had [DIAGNOSES REDACTED]. Observations on 03/10/20 at 3:40 pm revealed the hot water in room [ROOM NUMBER]'s bathroom sink was hot to touch by bare hand. Further observation revealed surveyors hand turned red in less than a minute. Observation on 03/10/20 at 3:58 pm revealed the hot water in room [ROOM NUMBER]'s bathroom sink registered 148.6 F. as per surveyor's thermometer. Observation on 03/10/20 at 4:00 pm reveled the hot water in room [ROOM NUMBER]'s bathroom sink registered 151.6 degrees F. as per surveyor's thermometer. On 03/10/20 at 4:05 pm the Maintenance Supervisor was informed of the temperatures on the 200 Hall. Surveyor requested temperatures be checked with the Facility's thermometer. Observation on 03/10/20 at 4:11 pm, revealed Maintenance Supervisor tested the hot water temperature in room [ROOM NUMBER] and it registered 130 degrees F (maintenance's thermometer) to 152.6 degrees F (surveyor's thermometer). Observation on 03/10/20 at 4:15 p.m., revealed Maintenance Supervisor tested the hot water in room [ROOM NUMBER] and it registered 130 degrees F. (maintenance's thermometer) to 153.6 degrees F. (surveyor's thermometer). In an interview on 03/10/20 at 4:16 pm the Maintenance Supervisor, confirmed his thermometer was not registering correctly. He further stated the hot water was too hot and knew it should not be over 110 degrees F. The Maintenance Supervisor stated the hot water in the 200 Hall was regulated by one water heater. In an interview on 03/10/20 at 4:30 pm, Medication Aide O revealed she had to mix cold water with the hot water, so the water was not as hot. Medication Aide O stated she had not told anyone. In an interview on 03/10/20 at 4:31 pm, Hospitality Aide P revealed the water temperatures on the 200 Hall get too hot. She stated it had been that way about a week. Further interview revealed she had not told anyone about the water being too hot. In an interview on 03/10/20 at 4:35 pm, Therapy Assistant N revealed the water has always been extremely too hot on the 200 Hall, since he had been working in the facility and that was almost a year. Further interview with Therapy Assistant N revealed he had not told anyone about the hot water. In an interview on 03/10/20 at 4:57 pm, the Maintenance Supervisor confirmed the hot water temperatures on the 200 Hall were registering high at 130 degrees F to 150 degrees F. During further interview the Maintenance Supervisor revealed he had only been there four days and been working on beds. He stated he had not looked to see if there were any water temperature logs. In an interview on 03/10/20 at 4:58 pm, the ADON revealed Residents #5, 11, 14, 15, 19, 21, 28, 41, 42, 43, 55,56 and 72 on the 200 Hall were ambulatory and had access to the water in the bathroom sinks. The ADON further stated these residents may not have the mental capacity and/or the sensation to know the water was hot. In an interview on 03/10/20 at 5:10 pm, Resident #59 revealed the water was weird and it needs to be fixed, because it gets very hot no matter what you do you cannot regulate it. Resident # 59 further stated he did not tell anyone. In an interview on 03/10/20 at 5:11 pm, Resident # 23's responsible party stated she does not wash her hands in Resident #23's sink (in 200 Hall), but goes down to the restroom at the 200 Hall nurse's station. The RP revealed the water had been very hot and it had been that way since Resident #23 was admitted to the facility 2 years ago. In an interview on 03/10/20 at 5:42 pm the Administrator revealed he was in the process of trying to contact the former Maintenance Supervisor, to see where the water temperature logs were. The Administrator stated Maintenance Supervisor H and him were unable to locate the temperature logs in the maintenance office. The Administrator stated they had adjusted water temperatures with the mixing valves weekly since he started at the facility in (NAME)2019, because the temperatures were high. After surveyor intervention: Observation on 03/10/20 from 5:44 pm to 6:01 pm revealed Maintenance Supervisor used a different thermometer and took water temperatures on the 200 Hall: room [ROOM NUMBER]- 101.7 degrees F Shower Room- 94.6 degrees F room [ROOM NUMBER]- 95.7 degrees F room [ROOM NUMBER]- 90.0 degrees F room [ROOM NUMBER]-96.3 degrees F room [ROOM NUMBER]- 94.0 degrees F Observation with the Maintenance Supervisor on 03/10/20 at 6:02 pm of the 200 Hall hot water heater revealed the hot water temperature gauge registered 94.0 degrees F. In an interview on 03/10/20 at 6:03 pm, the Maintenance Supervisor revealed he had the Maintenance Assistant M adjust the hot water, after the temperatures were checked the first time. The Maintenance Supervisor stated apparently he turned the hot water completely off and just had cold water running into the 200 Hall. Observation on 03/10/20 at 6:05 pm revealed the Maintenance Supervisor manipulated the hot water mixing valves (mixes hot and cold water together) that provided the water to the 200 Hall with a screw driver and then raised the hot water. Further observation revealed the temperature gauge on the hot water heater registered just under 110 degrees F. Observation with the Maintenance Supervisor on 03/10/20 at 6:20 to 6:28 pm revealed the water temperatures on the 200 Hall were: Shower Room- 100.7 degrees F room [ROOM NUMBER]- 104.7 degrees F room [ROOM NUMBER]- 101.4 degrees F room [ROOM NUMBER]- 103.4 degrees F room [ROOM NUMBER]- 104.5 degrees F In an interview on 03/11/20 at 10:46 am, Maintenance Assistant M revealed he had worked at the facility for almost [AGE] years. He stated the Maintenance Supervisor told him there was a problem with the water temperatures on the 200 Hall. Further interview revealed it had been an ongoing problem

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F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) for a long time. Maintenance Assistant M confirmed he had adjusted the hot water almost all the way up. He further stated he had adjusted the water many times for at least a year. He stated the old Administrator was aware and had tried to get it fixed. In an interview on 03/12/20 at 3:14 pm, the ADON revealed she had informed the Administrator that the hot water in the 200 Hall shower room was too hot and it took a long time for the water to come down (cool) . The ADON further stated the Administrator told her the former maintenance man would go and adjust the gauges to bring the temperature down. In an interview on 03/13/20 at 7:15 am, the Maintenance Supervisor revealed he had taken the water temperatures on 03/12/20 from 5:40 pm to 6:50 pm in rooms 201, 202, 206, 207, 210, 211, 213, 214, 218, 217, 221, 222 and the shower. The temperatures ranged from 101.8 degrees F to 107.4 degrees F. The Maintenance Supervisor stated water temperatures were checked again in the same rooms on the 200 Hall on 03/13/20 from 6:23 am to 7:07 pm and the hot water temperatures ranged from 103.1 degrees F to 108.5 degrees F. On 03/10/20 at 7:35 am the Administrator was informed of an Immediate Jeopardy (IJ) situation for the above failures, a completed IJ template was provided and a plan of removal was requested. The Plan of Removal was approved on 03/12/20 at 3:34 pm with immediate actions taken to be taken by the facility: Plan of Removal - Immediate Jeopardy (NAME)10, 2020 Immediate Action: The water was shut off to the B-hall resident rooms and the sink in the dining room. 100% of residents on the 200-hall were assessed for injury from hot water temps. There were no concerns or injuries from hot water temps. Staff were immediately notified to provide hand sanitation to residents by using hand sanitizer and/or if hands are visibly soiled to use the public restroom to wash their hands until the problem was corrected. Warm washcloths were provided for bedtime hygiene. A licensed plumber was called immediately upon discovery and the problem will be remediated as of (NAME)11, 2020 to bring the water temperatures to a safe and acceptable range of 100 - 110 degrees for residents. New mixing valves will be placed on the 200 hall water heater, as well as the water heater supplying water to the dining room sink. Water temperatures in the rest of the facility were taken and there were no concerns identified. Continued Compliance with Water Temperatures: 1. The maintenance director will monitor water temperatures in the affected areas; hourly until compliance on 200 hall rooms; twice a day for one week, once daily for one week, and following the regular established routine of weekly thereafter. 2. The Administrator will monitor water temperatures in the affected areas; twice a week for one week and randomly thereafter. 3. The Vice President will randomly check water temperatures in the affected areas during routine visits. 4. The Vice President initiated education with nursing staff (nurses and CNAs) regarding reporting water temperatures that appears too hot to the Administrator or designee and Maintenance Director, immediately. Staff not attending the initial education will be required to receive the education before working their next assigned shift. 5. The results of water temperature logs will be reviewed in the monthly Quality Assurance Performance Improvement meeting for three months for tracking, trending, and further recommendations, when needed. On 03/12/20 the Survey Team confirmed the Plan of Removal had been implemented sufficiently to remove the IJ. The surveyor verification of the POR was as follows: Interviews were conducted with staff The questions asked were: 1. Have you had any issues with the hot water on the 200 Hall/B Hall? 2. If yes- Did you tell anyone? 3. Have you had any in- services since 03/10/20? If yes- What In services? 4. What did you learn? Staff interviewed on the 100 Hall and the 200 Hall to include, the DON and ADON, 4 LVN Charge Nurses,(B, Z, AA, DD), 6 CNAs,(D,R, S, T, U, V), 2 Laundry/Housekeeper,(W, EE), 3 Food Service Aides, (Q, X, Y), Dietary Manager, 1 RN (BB) and HR/ABOM. stated they were not aware of the hot water issues on the 200 Hall. They were in-serviced and instructed if the water was too hot to report it to the Charge Nurse, ADON, DON or the Administrator. The In-services provided to the staff were reviewed from 03/10/20 to 03/12/20 at 7:30 am. On 3/12/2020 at 3:34 p.m. the Administrator was informed the IJ was removed. However, the facility remained out of compliance at severity level of potential for harm with a scope identified as a pattern until the water heater and regulator was repaired and all staff were in-serviced.
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 that a resident with an indwelling urinary catheter received appropriate treatment and services for 1 of 1 resident (Resident #4) reviewed for catheter care, in that: Resident #4 was observed to have her catheter bag on the floor. This deficient practice could affect residents with urinary catheters and place them at risk for an increased risk for infection. The findings were: Record review of Resident #4's face sheet, dated 3/12/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's Physician order [REDACTED].#4's care plan, undated, revealed the care area: requires an indwelling urinary catheter related to [DIAGNOSES REDACTED].#4 was in bed with the tubing to the indwelling catheter draining to gravity on the resident's left side and the catheter bag sitting on the floor under the bed. During an interview on 3/11/20 at 10:18 a.m., LVN B confirmed Resident #4's indwelling catheter bag was on the floor under the resident's bed and stated the catheter bag should not have been touching on the floor because it was considered cross contamination. At the time of the exit, the DON did not provide a copy of the Indwelling Urinary Catheter policy requested on 3/13/2020.
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 residents who needed respiratory care were provided such care, consistent with professional standards of practice for 1 of 3 residents (Resident #3) reviewed for respiratory care in that: Resident #3's oxygen tubing and humidifier bottle were not labeled and dated. This deficient practice could affect residents who received oxygen therapy and could result in an increase in respiratory complications and respiratory infections. The findings were: Record review of Resident #3's face sheet, dated 3/12/20, revealed an admission date of [DATE] and re-admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's most recent Annual MDS, dated [DATE], revealed a BIMS score of 15 which indicated the resident was cognitively intact for daily decision-making skills. Record review of Resident #3's Physician order [REDACTED]. Observation on 3/10/20 at 10:38 a.m. revealed Resident #3 sitting up in a recliner with the oxygen concentrator operating at 2 liters per minute via nasal cannula. Further observation revealed the oxygen tubing and the humidifier bottle were not labeled/dated. During an interview on 3/10/20 at 10:41 a.m., LVN B confirmed Resident #3's oxygen tubing and humidifier bottle were not labeled or dated. LVN B further stated Resident #3 had only recently been admitted to receive hospice services, but stated it was the responsiblity of the facility staff to ensure the oxygen tubing and humidifier bottle were labeled or dated. During an interview on 3/10/20 at 10:47 a.m., the ADON confirmed the oxygen concentrator tubing and humidifier bottle provided to Resident #3 should have been labeled with a date. At the time of the exit, the DON did not provide a copy of the facility policy for oxygen administration or oxygen equipment requested on 3/13/20.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that 1 of 3 nurse aides (CNA C) demonstrated competency in skills and techniques necessary to care for resident needs for 1 of 3 Residents (Resident #60) observed during perineal care in that: CNA C failed to clean the buttocks while providing incontinent/pericare for Resident #60. This deficient practice could affect residents who required incontinent care and could place them at risk for skin breakdown and cross contamination. The findings were: Record review of Resident #60's Face Sheet, dated 03/13/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #60's Admission MDS dated [DATE], revealed Resident #60 was moderately cognitively impaired for daily decision-making skills. Further review revealed Resident #60 was always incontinent of bowel and had an indwelling catheter. Observation on 03/13/2020 at 9:15 a.m. during incontinent/ peri care and catheter care for Resident #60 revealed CNA C did not clean the buttocks. Interview on 03/13/2020 at 9:15 a.m. CNA C confirmed he realized he did not clean the buttocks while providing incontinent/peri care and catheter care to Resident #60. Interview on 3/13/2020 at 10:10 a.m., the ADON revealed CNA C just had a review of incontinent care skills. The ADON stated Resident #60 already had a UTI from his urinary catheter. Review of the facility document titled Perineal Care, revision date October 2010, revealed in part .10f. turn resident on his side h. Wash and rinse the rectal area thoroughly, including . the buttocks

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assure drugs and biologicals were secured properly in 1 of 1 Medication rooms (B Wing) and 1 of 2 Medication carts (A Wing) observed, in that: 1. In the medication room for B Wing, three bottles of Latanoprost 0.005% ophthalmic solution had expired dates of ,[DATE], ,[DATE] and ,[DATE]. 2. In the medication cart for A Wing, a urinary catheter insertion kit was found with an expiration date of [DATE]. This deficient practice could place residents who receive medications from the medication room to be placed at risk for not receiving the intended therapeutic benefit of their medications; and residents who require an inserted urinary catheter may have the sterility and pre-lube tip compromised and could result in discomfort and infection. The findings were: 1. Observation on [DATE] at 08:30 a.m. during medication storage checks with RN A revealed three bottles of Latanoprost 0.005% ophthalmic solution had expired dates of ,[DATE], ,[DATE] and ,[DATE]. In an interview with RN A on [DATE] at 08:45 a.m. she confirmed there were 3 bottles of expired eye drop solution in the medication room. 2. Observation on [DATE] at 10:30 a.m. during medication cart storage checks with LVN B revealed a urinary catheter insertion kit in the bottom drawer with an expiration date of [DATE]. In an interview with LVN B on [DATE] at 10:40 a.m. she confirmed the urinary catheter insertion kit needed to be taken off the cart due to the expiration date. Review of facility policy and procedure dated revised (NAME)2007 and titled Storage of Medications read in part .all outdated or deteriorated drugs or biologicals shall be returned to the dispensing pharmacy or destroyed.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 (main kitchen) reviewed for kitchen sanitation in that: 1. Chopped Potatoes stored in 1 of 1 walk-in freezer were unsealed and not dated. 2. Twenty hard boiled eggs stored in 1 of 1 walk-in refrigerator had an expiration date of [DATE]. 3. Yogurt stored in 1 of 1 walk-in refrigerator had an expiration date of [DATE]. 4. One gallon of milk stored in 1 of 1 walk-in refrigerator had no opened date. These deficient practices could place residents who received meals from the main kitchen at risk for food borne illness. The findings were: 1. Observation of the walk-in freezer on [DATE] at 09:30 a.m. revealed a bag of chopped potatoes opened and stored in the freezer unsealed and not dated. 2. Observation of the walk-in refrigerator revealed twenty hard-boiled eggs sealed in the original manufacture packaging with an expiration date of [DATE]. 3. Observation of the walk-in refrigerator on [DATE] at 9:40 a.m. revealed a yogurt container with an expiration date of [DATE]. 4. Observation of the walk-in refrigerator on [DATE] at 9:40 a.m. revealed a gallon of milk with no opened date. During an interview on [DATE] at 9:35 a.m., Dietary Manager Q confirmed the chopped potatoes in the walk-in freezer were opened and unsealed and did not have a label with an opened date. Dietary Manager Q confirmed the hard-boiled eggs and the yogurt in the walk-in refrigerator were expired. Dietary Manager Q confirmed the milk in the walk-in refrigerator did not have an opened date on the label. Record review of the Texas Food Establishment Rules, [DATE], 228.75(g) Ready-to eat, time/temperature controlled for safety food, date marking. (1) Refrigerated, ready-to-eat, time/temperature controlled for safety, food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees F or less for a maximum of 7 days. (2) Refrigerated, ready-to-eat, time/temperature controlled for safety food prepared and packaged by a food processing plant shall be clearly be marked at the time the original container is opened in a food establishment and held at a temperature of 41 degrees Fahrenheit or less if the food is held for more than twenty-four hours. At the time of the exit, Dietary Manager Q did not provide a copy of the Food Procurement policy requested on [DATE].
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Dispose of garbage and refuse properly.** Based on observation and interview the facility failed to dispose of garbage and refuse properly in that: 1. The dumpster's top lid was open for 3 days (Days #1, #2 and #3) of four survey days. 2. The dumpster's sliding door was open for 3 days (Days #1, #2 and #3) of four survey days. 3. At the front of the dumpster there was an old recliner and a pallet of wood on the ground. These deficient practices posed a sanitary and safety hazard that could result in the attraction of vermin and rodents and could affect all residents residing in the facility by exposing them to germs and diseases carried by vermin and rodents. The findings were: Observation on 3/10/2020 at 11:25 a.m. revealed there was 1 dumpster outside the facility. The front-sliding doors on the dumpster were open approximately a foot. The dumpster's top lid was open exposing the contents inside. Further observation on 3/11/2020 at 2:52 p.m. and 3/12/2020 at 10:56 a.m. revealed the front-sliding doors were left open on the dumpster. During an interview on 3/12/2020 at 10:56 a.m. Restorative Aide FF confirmed the sliding doors and the top lid of the dumpster were open exposing the contents. During an interview on 3/12/2020 at 2:30 p.m. with Dietary Manager Q she confirmed she could view the dumpster from the window in her office area in the kitchen and had seen the dumpster left open for the last 3 days. Record review of the Texas Food Establishment Rules 2015, p. 116, 229.166(l)(14)(B) revealed waste receptacles kept outside of the food establishment are to be covered with tight-fitting lids or doors.
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 interviews, and record reviews, the facility failed to maintain clinical records that were complete and accurate, and in accordance with accepted professional standards and practices, for 1 of 11 resident (Resident #75) reviewed, in that: Resident #75 had two medications that were ordered by mouth and they should have been ordered to be administered by PE[DEVICE]. This deficient practice could affect residents that reside in the facility and could result in errors in care and treatment. The findings were: Record review of Resident #75's face sheet, dated 03/11/2020 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #75's Quarterly MDS dated [DATE] revealed short term and long-term memory loss with severe cognitive impairment for daily decision-making skills. Record review of Resident #75's physician's orders [REDACTED]. -Tylenol Extra Strength ([MEDICATION NAME]) 500mg tablet, 2 tablets oral as needed for pain or fever. Record review of Resident #75's MAR indicated [REDACTED]. Record review of Resident #75's Care Plan with last review date of 3/4/2020, revealed a problem that Resident #75 was NPO (nothing by mouth) status and was at high risk of aspiration, nutritional impairment and complications due to dysphagia related to history of [MEDICAL CONDITION]. During an Interview on 03/11/2020 at 11:00 a.m. the DON confirmed the orders for Atorvastatin and Tylenol were incorrectly written as Resident #75 was NPO and all medications should be given through the PE[DEVICE]. At the time of the exit, the DON did not provide a copy of the policy for Accuracy of Clinical Records requested on 3/13/2020.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 Resident on isolation precautions (Resident

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	676301	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN WINDS LIVING & REHABILITATION	3301 FM 3009 SCHERTZ, TX 78154

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) #2), 1 of 1 Resident provided wound care (Resident #32), 1 of 3 Residents being provided incontinent/peri care, catheter care (Resident # 60), Residents who ate lunch in the dining room, and 1 of 1 medication rooms observed for infection control practices, in that: 1. LVN B entered Resident #2's room without donning PPE (Personal Protective Equipment). Resident #2 was placed in a room without a sink. 2. RN BB entered Resident #32's room to perform wound care and did not wash or sanitize her hands before or after the wound care. 3. CNA C failed to change gloves, wash or sanitize his hands while providing incontinent/ peri care and catheter care for Resident #60. 4. Dietary Aide K did not wash or sanitize her hands when providing beverages to several residents in the dining room. 5. Two open bags of adult briefs were stored on the floor in the medication room on 200 Hall/B Wing. These deficient practices could place residents who were on isolation due to infection, receiving wound care, receiving incontinent/peri care and catheter care, wearing adult briefs and residents who consume beverages in the dining room at risk of cross contamination and infections. The findings were: 1. Record review of Resident #2's face sheet, dated 3/12/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #2's most recent quarterly MDS dated [DATE] revealed a BIMS score of 6 which indicated the resident was severely cognitively impaired for daily decision-making skills. Further review of the quarterly MDS revealed Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's Physician Order Report from 2/10/20 to 3/10/20 revealed an order for [REDACTED].#2 had a PPE cart outside the resident's bedroom in the hallway and a sign on the wall at the bedroom entrance indicating the resident was on isolation. Further observation revealed LVN B walked into Resident #2's room without PPE and took the resident's food tray from the bedside table and tossed it into the biohazard box in the room. Observation on 3/10/20 at 10:12 a.m., after an attempted interview with Resident #2, revealed after this surveyor removed her PPE it was noted that there was no sink to wash my hands and no hand sanitizer in the room. During an interview on 3/10/20 at 10:13 a.m. LVN B stated Resident #2 was placed on contact isolation beginning 3/7/20 due to possible [MEDICAL CONDITION] ([MEDICAL CONDITIONS]). LVN B stated she should not have walked into Resident #2's room without PPE but further stated that the resident's stool always stunk and results from the stool sample had not yet been confirmed for [MEDICAL CONDITION]. LVN B stated Resident #2's room did not have a sink and staff entering the room had to walk out of the room, past the nurse's station and walk into the dining room where there was a sink with running water for the staff to wash their hands. During an interview on 3/11/20 at 8:24 a.m., the DON, ADON and interim Administrator confirmed staff should not be entering Resident #2's room without PPE. The DON confirmed Resident #2 was in a room that did not have a sink with running water and the resident needed to be moved. 2. Record review of Resident #32's face sheet ,dated3/12/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #32's most recent quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated the resident was moderately cognitive impaired for daily decision-making skills. Record review of Resident 32's Physician Order Report from 2/11/2020-3/11/2020 revealed an open-ended order dated 02/05/2020 to cleanse Stage III coccyx wound with wound cleanser, pat dry, apply collagen and cover with dry dressing daily. Observation on 3/13/2020 revealed RN BB entered room and did not wash hands, used sanitizer and placed gloves on hands and then assisted with pulling curtain and removing residents clothing. RR BB then changed gloves without washing hands and preceded to perform wound treatment. RN BB used her fingers with a glove in place to apply the collagen into the open wound. RN BB then left room and went down the hallway without washing hands before leaving the Residents room. During an interview with RN BB on 3/13/2020 at 10:15 a.m. she stated the policy allows for the nurse to either wash her hands or use sanitizer before donning gloves. She states there was no policy that required staff to wash hands when entering or exiting a resident's room. During an interview with the D.O.N. on 3/13/2020 at 1:00 p.m. the D.O.N confirmed that her expectation is that all staff wash their hands when entering and when exiting a resident's room. She further confirmed that the facility had a policy that required staff to wash hands before and after direct resident contact and before and after dressing changes. 3. Record review of Resident #60's Face Sheet, dated 03/13/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #60's Admission MDS dated [DATE], revealed Resident #60 was moderately cognitively impaired for daily decision-making skills. Further review of the Admission MDS revealed Resident #60 was always incontinent of bowel and had an indwelling catheter. Record review of Resident #60's Care Plan dated 11/19 revealed the resident was incontinent of bowel and had a catheter and to provide incontinent care after each incontinent episode. During an observation on 03/13/20 at 9:02 a.m., while CNA C prepared to provide Resident #60 with incontinent/ peri care and catheter care revealed CNA C washed his hands and donned a pair of gloves . CNA C then went to Resident #60's bedside and took the remote to raise the bed and lowered the head. With the same gloves on, CNA C assisted CNA D to remove the soiled brief. As CNA C was cleaning the front of Resident #60, CNA C dropped a wet wipe on the floor, picked it up and placed in the trash and continued to provide the peri care and clean the catheter without removing the soiled gloves or washing or sanitizing his hands and donning a clean pair of gloves. The surveyor then stopped the procedure. Interview on 03/13/20 at 9:10 am, CNA C revealed he had kept the soiled gloves on after touching the remote control on the bed and reaching down to pick up a soiled wet wipe off the floor without removing his gloves, washing or sanitizing his hands and donning a clean pair of gloves to continue with the incontinent/ peri care and catheter care. Interview on 3/13/2020 at 10:10 a.m., the ADON revealed CNA C just had a review for incontinent care. The ADON also stated Resident #60 already had a UTI from his catheter. Review of the facility procedure for Perineal Care with revision dated October 2010, has documented under 7. to put on gloves.,Further review revealed nodocumented evidence for glove changing and washing or sanitizing hands. 4. During dining observation on 3/10/20 at 12:07 p.m. Dietary Aide K was observed distributing drinks to several residents from a beverage cart. Dietary Aide K was observed cleaning her right hand with her apron, then touching a resident's wheelchair handle with her left hand, touching a visitor's right shoulder with her right hand, holding a resident's left hand with her right hand in greeting and filling coffee cups with water and mixing them with packets of hot cocoa mix without washing or sanitizing her hands. Further observation revealed Dietary Aide K was observed picking up 4 packets of hot cocoa mix off the floor after they had been accidentally dropped and proceeded to serve them to the residents. During an interview on 3/10/20 at 12:16 p.m. Dietary Aide K confirmed she had dropped several packets of hot cocoa mix on the floor and continued to use them. Dietary Aide K stated they (hot cocoa packets) weren't hurt since it wasn't open or spilled and were ok to use. Dietary Aide K further stated she did not carry sanitizer on the beverage cart and further stated she did not wash or sanitize her hands at least not today, but I probably should have. 5. Observation on 3/12/20 at 08:40 a.m. during medication storage room checks revealed there were two bags of open adult briefs stored on the floor. In an interview on 3/12/20 at 08:45 a.m. with RN A, she confirmed the open bags of clean adult briefs should not be on the floor. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions, revision date 4/2012, revealed in part .Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others .In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room .remove gloves before leaving the room and perform hand hygiene . Review of the facility policy titled Handwashing/Hand Hygiene, revision date (NAME)2012, revealed in part .All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors .When to wash hands .Before and after direct resident contact .Before and after entering isolation precaution settings .Before and after assisting a resident with meals .Upon and after coming in contact with a resident's intact skin . Record review of the policy titled Handwashing/Hand Hygiene with a revision date of (NAME)2012 #5 read in part, Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practices). k. Before and after changing a dressing r. After handling soiled or used linens, dressing, bedpans, catheters and urinals .
F 0908 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Keep all essential equipment working safely.** Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition in 1 of 1 (main kitchen), in that: 1. The 3-compartment sink had a leaking pipe in the elbow and staff were collecting water into a bucket under the sink 2. The ice machine had a leak, and water was found to be pooling underneath the machine. These deficient practices could affect residents at the facility who ate

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F 0908 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 5) meals/snacks prepared by the facility kitchen and place them at-risk of foodborne illness, poor intake, and/or weight loss. The findings were: 1. Observation of the kitchen on 03/11/2020 at 09:30 a.m. revealed a medium sized dish pan under the sink catching water from a leaking pipe. Food was being prepared in areas adjacent to the leaking sink. During an interview on 3/11/2020 at 9:35 a.m., the Dietary Manager Q confirmed the 3-compartment sink had been leaking for a couple of weeks. 2. Observation on 03/11/2020 at 10:00 a.m., revealed water pooling under the ice machine located in the kitchen. During an interview on 03/11/2020 at 10:05 a.m. Dietary Manager Q confirmed water was pooling underneath the ice machine. Review of the Texas Food Establishment Rules (TFER) 2015, page 88, section 228.103 a. revealed equipment and utensils shall be designed and constructed to be durable and to retain their characteristic qualities under normal use conditions. At the time of the exit, Dietary Manager Q did not provide a copy of the Safe Operating Condition of Equipment requested on 3/13/2020.
F 0912 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a minimum of 80 square feet per resident for residents in 4 of 4 multiple occupancy resident rooms (Rooms 112, 114, 116, and 118) reviewed for room size variance, in that: Rooms 112, 114, 116, and 118 did not have the required minimum of 80 square feet per resident. This deficient practice could affect residents placed in these multiple occupancy rooms by reducing their living space and posing problems in their activities of daily living. The findings were: Observation on 03/11/2020 at 10:38 a.m. revealed the following measurements of resident room dimensions for the room size waiver: 1. room [ROOM NUMBER] (3 person room - 2 residents in room) - 227.11 sq ft. / 3 residents = 75.70 sq ft./resident 2. room [ROOM NUMBER] (3 person room - 2 residents in room) - 226.68 sq ft. / 3 residents = 75.56 sq ft./resident 3. room [ROOM NUMBER] (3 person room - 2 residents in room) - 226.58 sq ft. / 3 residents = 75.53 sq ft./resident 4. room [ROOM NUMBER] (3 person room - 2 residents in room) - 226.12 sq ft. / 3 residents = 75.37 sq ft./resident During an interview with the Acting Administrator on 03/13/2020 at 9:25 a.m. she confirmed the dimensions for Rooms 112, 114, 116, and 118 had less than the 80 square feet per resident in the rooms. The Acting Administrator further confirmed the facility would like to continue with the room size waiver for the aforementioned resident rooms.