STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676083	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSVILLE NURSING AND REHABILITATION CENTER	**320 LORENALY DR BROWNSVILLE, TX 78520**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's representative when there was a significant change in the resident's physical health status, for one Resident (R#1) of three residents reviewed for notification of changes, in that: The facility failed to notify R#1's RP that R#1 tested positive for COVID-19. This failure placed residents at risk of not having family to advocate for them. Findings included: Record review of R#1's Admission Record revealed R#1 was an [AGE] year-old female who was initially admitted on [DATE] and was re-admitted on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Comprehensive Care plan, initiated on 07/22/20, revealed R#1 was at risk for deterioration of medical condition due to positive results of COVID-19. Results were received on 07/21/20. Risk factors included hypertension and [MEDICAL CONDITION]. Interventions included contact/droplet precautions in place due to positive COVID-19 test, to provide medications or treatments as ordered, and to observe for effectiveness. Record review of R#1's Significant Change in Status MDS assessment, dated 07/24/20, revealed R#1; -had moderately impaired cognitive status, -required extensive assistance by two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene, and -had active [DIAGNOSES REDACTED]. In an interview on 08/05/20 at 11:05 a.m., the Administrator said non-nursing staff had been assigned on 07/21/20 to call the RPs of all 32 residents who had tested positive for COVID-19. The Administrator said each staff member had been assigned certain RP's to contact in a mass communication effort to contact all of the 32 residents' RPs with positive test results for COVID-19. The Administrator said staff would indicate on the Census Report if staff had contacted each resident's RP or left a voicemail. The Administrator said the facility did not have a policy or procedure to address the communication process for RPs regarding any changes in health conditions. Record review of R#1's nurse's notes, dated 07/23/20, revealed R#1's MD was notified of R#1's positive COVID test results. Notes did not indicate R#1's RP had been notified of the positive COVID results for R#1. On 08/05/20 at 11:32 a.m., the DON said that, on 07/21/20, non-nurses were designated to contact residents' RPs with information on positive COVID-19 test results. The staff were required to document on the Census Report about the contacts made or messages was left on the RPs' voicemail. In an interview on 08/05/20 at 12:18 p.m., Medical Records staff said she was told to call certain resident's RPs to inform them about the COVID-19 positive results for those residents. Medical Records staff said she called R#1's RP and did not get an answer. Medical Records staff said she left a voicemail identifying herself and asked the RP to call back regarding some information to be provided. Medical Records staff said some of the residents' RPs returned her calls and she provided the information regarding positive COVID results. Medical Records staff said R#1's RP was the only RP that she left a voicemail to call back who did not respond. Medical Records staff said she did not recall R#1's RP calling her back. Medical Records staff said she did not make any additional attempts to contact R#1's RP after she left the voicemail. In an interview on 08/05/20 at 1:45 p.m. the BOM revealed she was assigned to call RPs to inform them of positive COVID-19 results for some residents in 100 hall. If no answer was obtained, she would leave a voicemail message to call back regarding some results that were received. The BOM said she documented who she contacted and those that she left a voicemail message. The BOM said she was able to call 15 RPs and had to leave four voicemail messages to call her back for the test results. The BOM said two of the RPs with voicemail messages returned her call and she informed those RPs of the results. Two voicemail messages she left did not return her calls. The BOM said she notified the Administrator about not getting a call back on the two residents that she had left a voicemail message. The BOM said she did not attempt to contact the two RP's that did not call back. In an interview on 08/05/20 at 1:29 p.m., R#1's RP said he received a call on 08/02/20 to inform him that R#1 was being transferred to the hospital. R#1's RP said he was not told on that date that R#1 was positive for COVD-19. R#1's RP said he was not contacted by facility staff prior to that date to inform him R#1 was positive for COVID. R#1's RP said his family member called him to inform him he had read in the news that this facility had many COVID positive cases. R#1's RP was told R#1 was COVID positive by a family member who called the hospital and was informed by hospital staff.
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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, for two Residents (R#2 and R#3) of five residents reviewed for care plans in that: 1) R#2's weekly skin assessments were not implemented as per care plan. 2) R#3's care plans did not address DTIs to the coccyx and left and right buttocks. These failures could place residents at risk for not receiving necessary care and services. The findings were: 1) Record review of R#2's Admission Record, dated 08/05/20, revealed R#2 was a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's Comprehensive Order Summary Report, dated 08/05/20, revealed an order to: cleanse stage 4 to left buttock with ns pat dry, apply therabond dressing cover with [MEDICATION NAME] daily, every shift for healing stage four, start date 07/26/20. Record review of R#2's Quarterly MDS assessment, dated 06/22/20, revealed R#2: -had independent cognitive skills for decision making, -required extensive assistance from staff for bed mobility, dressing, toilet use, and personal hygiene, and -had a stage 4 pressure ulcer upon admission or re-entry. Record review of R#2's, Weekly Pressure Ulcer Evaluation dated 07/15/20, revealed R#2 had a left gluteal fold pressure ulcer that measured 2.7 cm in length, 1.0 cm in width and 0.1 cm in depth. Date wound developed indicated 11/23/18. Record review of R#2's care plans revealed R#2 was at risk for complications from wound to buttocks, date initiated 09/12/18. Interventions included: - monitor R#2 for s/s of infection, drainage, swelling or foul odor. Record review of R#2's care plans revealed R#2 was at risk for further skin integrity r/t decreased mobility and history of impaired skin integrity and incontinence, start date 10/25/19. Interventions included: - weekly skin assessments. Observation of R#2 on 08/05/20 at 4:05 p.m. revealed R#2 was in bed, alert and oriented. R#2 said she remembered she sometimes received treatment for [REDACTED]. R#2 said she did not have any concerns with the care provided for her wound. In an interview on 08/05/20 at 2:50 p.m., the DON revealed weekly skin assessments were not being completed because the Wound Treatment nurse was working as a Charge Nurse at night. The DON said each LVN was responsible to do wound treatments as needed for the residents in their care. The DON said the last weekly skin assessment for R#2 had been completed on 07/15/20. In an interview on 08/05/20 at 1:40 p.m., LVN A said she did wound treatments for R#2 as ordered by

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) the physician and documented on R#2's TARs. LVN A said she did not do weekly skin assessments. LVN A said she thought another nurse was assigned to do weekly skin assessments. Record review of the nurse's notes for R#2 revealed LVN B did wound care and noticed, stage 4 to left buttocks, healing well, presenting as stage 2, 2.0 cm x 0.36 cm x 0.1 cm, red granulating wound bed, no depth and no undermining. As per MD new order to discontinue the [DEVICE] and start therabond dressing daily. In an interview on 08/05/20 at 4:03 p.m., the DON said the facility did not have a written policy on skin care or treatments. 2) Record review of R#3's Admission Record, dated 08/05/20, revealed R#3 was an [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. R#3's [DIAGNOSES REDACTED]. Record review of R#3's Comprehensive Order Summary Report, dated 08/05/20, revealed an order to cleanse DTI to coccyx with ns, pat dry, apply zinc oxide cream, cover with gauze and [MEDICATION NAME] dressing daily every evening shift for dti, start date 07/21/20. Record review of R#3's Quarterly MDS assessment, dated 07/30/20, revealed R#3: -had severely impaired cognitive skills for decision making, -required extensive assistance from staff for bed mobility, dressing, toilet use, and personal hygiene, and -had one unstageable pressure injury presenting as deep tissue injury. Record review of R#3's, Weekly Pressure Ulcer Evaluation dated 07/14/20, revealed R#3 had a suspected deep tissue injury to the left buttock that measured 5.0 cm in length, 3.0 cm in width and 0 cm in depth. Date wound developed indicated on 07/14/20. Coccyx pressure wound measuring 2.0 cm x 2.0 cm x 0 cm suspected deep tissue injury developed on 07/14/20. Record review of R#3's Change of Condition Communication Form, dated 07/14/20, revealed: Resident with 3 DTIs left buttock, 5 x 3 x 0 coccyx, 2 x 2 x 0 right buttock, 2.5 x 2 dark purple/maroon intact skin, tissue firm. Record review of the Comprehensive Care Plans for R#3 revealed a focus on potential impairment to skin integrity, revised on 12/03/19. Interventions included to keep skin clean and dry and use caution during transfers and bed mobility to prevent striking arms, legs and hands. Care plans did not address the DTIs identified on 07/14/20. In an interview on 08/05/20 at 3:20 p.m., LVN/MDS Coordinator C said she had not developed a care plan to address R#3's three DTI's that were identified on 07/14/20. LVN/MDS Coordinator C said Doctor's orders had been received for care and treatment. LVN/MDS Coordinator C said she should have developed care plans to address R#3's DTIs. LVN/Coordinator said she was behind on addressing doctor's orders into care plans for R#3. In an interview on 08/05/20 at 3:38 p.m., LVN A said R#3 had DTIs and she (LVN A) did not do R#3's treatments. LVN A said the night nurse did R#3's wound treatments. LVN A said a care plan informed and addressed the care to be provided to a specific concern and the interventions would be included in the care plan to inform staff of the care to be provided. LVN A said the doctor's orders and care plan gave direction on how to provide care. LVN A said staff should follow care plans and doctor's orders to provide care. In an interview on 08/05/20 at 3:55 p.m., R#3 was observed in her low bed, awake and alert. R#3 said she did not remember getting any skin care or treatments. In an interview on 08/05/20 at 4:03 p.m., the DON said a care plan to address R#3's DTI's had not been developed as needed. Record review of facility's policy titled, Care Planning, dated December 2017, revealed: A comprehensive, person centered care plan is developed and implemented for each resident to meet the resident's physical, psychosocial and functional needs.