STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455423	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCC AT VALLEY GRANDE	901 WILDROSE LN 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 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respect the resident's right to personal privacy during personal care, for one Resident (R#1) of six residents reviewed for privacy issues, in that: LVN A and CNA B did not provide full visual privacy when conducting a skin assessment on R#1. This failure could place residents that were dependent upon care at risk for embarrassment, poor self-esteem, and unmet needs. The findings were: Record review of R#1's Admission Record, dated 03/11/20, revealed R#1 was 80-years-old and was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's MDS assessment, dated 02/10/20, revealed R#1: -had clear speech, -was understood by others, -was sometimes able to understand others, -had severely impaired cognition, and -required extensive assistance for all ADLs. Record review of R#1's Care Plan, dated 07/10/19, revealed: The resident has impaired cognitive function/dementia or impaired thought processes. Observation on 03/11/20 at 1:40 p.m., revealed LVN A and CNA B conducted a skin assessment on R#1. CNA B closed the door to R#1's room. The curtain to the left of R#1 was closed, however, the curtain to the right of R#1's bed was not long enough to provide full visual privacy for R#1. Further observation revealed LVN A pulled the curtain to provide full visual privacy for R#1 but when the curtain was pulled towards the foot of the bed, the part of the curtain at the head of the bed would open and expose the resident. In an interview on 03/11/20 at 1:42 p.m., LVN A and CNA B acknowledged the curtain to the right side of the bed was too short and they were not able to provide full visual privacy for R#1. CNA B said the curtain had been like that since R#1 had been in the room. CNA B said she had not reported it to maintenance. In an interview on 03/11/20 at 4:46 p.m., the Administrator said the residents needed to be provided with full visual privacy during ADL care and other procedures performed by staff. Record review of the facility undated policy titled, Privacy and Confidentiality, revealed: Personal privacy will be provided for accommodations, medical treatment, written and telephone communications, personal care, visits and meeting of family and resident groups .
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 nursing staff had the competencies and skill sets to provide nursing and related services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, for one Resident (R#2) of six residents reviewed, in that: 1) CNA C did not report multiple discolorations on R#2's arms. 2) The facility nurses did not conduct weekly skin assessments on R#2. These failures could affect residents with a potential for skin breakdown and place them at risk for abuse, neglect, and skin breakdown. The findings included: Record review of R#2's Admission Record, dated 03/11/20, revealed R#2 was 83-years-old and was admitted to the facility on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's MDS assessment, dated 01/23/20, revealed R#2: -had clear speech, -was usually understood by others, -was usually able to understand others, -had moderate cognitive impairment, and -required supervision only to perform ADLs. Record review of R#2's care plan, dated 06/28/18 and revised on 10/28/19, revealed: Problem: I am on antiplatelet therapy r/t CAD. Interventions: Monitor and report to MD any adverse effects such as unusual bruising, bloody or black tarry stools, red or dark brown urine, abdominal pain or swelling, bleeding from eyes, nose, or gums. On 03/11/20 at 9:27 a.m., Surveyor conducted an interview with R#2 in her room and observed discolorations to R#2's arms. R#2 had approximately nickel-sized oval shaped purple discolorations, two to her right forearm, one to the right elbow, and one to the left wrist. R#2 said she did not know how she got the discolorations. R#2 said she thought someone poked her at night with a needle because staff tends to poke her with needles at night when she was asleep. R#2 said she did not know when this happened. Record review of R#2's progress notes from 12/23/19 - 0[DATE] revealed no documentation of the discolorations to R#2's arms. In an interview on 03/11/20 at 2:30 p.m., ADON G was asked for skin assessments for the months of February and March 2020 for R#2. ADON G said the staff had not been doing weekly skin assessments on the skin assessment forms due to a change in the computer system. ADON G said they had not been aware there were forms available specifically for skin assessments. ADON G said she believed the weekly skin assessments were being conducted by the floor nurses and documented in the progress notes. ADON G said if the nurses saw a new skin issue with a resident it was documented but if there were no issues there would not be a progress note. ADON G presented R#2's Skin Observation Tool dated 03/11/20. ADON G said she told LVN F to conduct the skin assessment after surveyor requested the skin assessments for R#2. Record review of R#2's, Skin Observation Tool, dated 03/11/20 at 2:16 p.m. revealed R#2 had discolorations to the right elbow, left wrist, and right forearm. There was no description of size or color. Record review of R#2's progress notes, dated 03/11/20 at 2:34 p.m., revealed: Upon skin assessment, SN noted multiple dark purple discolorations to the resident's left wrist x1, right elbow x1 and right forearm x2. Resident states she does not remember how she got them, states she thinks they happened at night when she is sleeping due to not remembering. SN notified MD resident currently on [MEDICATION NAME] 75mg QD. No new orders given at this time. ADON (name) made aware. The note was signed by LVN F. In an interview on 03/11/20 at 2:56 p.m., LVN A said she was a Charge Nurse. LVN A said she had not been conducting weekly skin assessments on the residents because it was her understanding that the Treatment Nurse was conducting the weekly skin assessments. In an interview on 03/11/20 at 2:59 p.m., LVN F said she conducted the skin assessment on R#2 today and discovered R#2 had multiple discolorations to both arms. LVN F said she had not been aware of the discolorations because R#2 was independent in her ADLs and always wore sweaters covering her arms. LVN F said CNAs had not reported the discolorations. In an interview on 03/11/20 at 3:16 p.m., LVN H said she was not the full-time Treatment Nurse. LVN H said the facility did not have a full-time Treatment Nurse. LVN H said she would just cover when the nurses needed her to do a wound care on the residents. LVN H said each nurse was responsible for conducting wound care on their assigned residents. LVN H said each floor nurse was responsible for conducting their own weekly skin assessments on their residents since they did not have a full-time Treatment Nurse. LVN H said they had not had a full-time Treatment Nurse for about three months. In a telephone interview on 03/11/20 at 4:03 p.m., CNA C said on her first day back at work, (Saturday 03/07/20) she noticed the discolorations to R#2's arms. CNA C said she mentioned the discolorations to CNA D and asked CNA D if she had been aware of the discolorations. CNA C said CNA D said she was aware of the discolorations and that they had probably already been reported. CNA C said when she went into R#2's room, R#2 mentioned someone had poked her with a needle early in the morning. CNA C said she thought that someone had drawn blood from R#2. CNA C said she did not report the discolorations to R#2's arms to the nurse because she assumed they were already reported by someone else. In a telephone interview on 03/11/20 at 4:19 p.m., CNA D said she was not aware of discolorations to R#2's arms. CNA D denied anyone mentioning to her that they had seen discolorations to R#2's arms. In an interview on 03/11/20 at 4:46 p.m., the Administrator said the CNAs should report any changes in condition of the resident's skin to the nurse immediately. The Administrator said they were in the process of hiring a full-time Treatment

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 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Nurse, but in the meantime, the floor nurses should conduct the weekly skin assessments. The undated facility policy titled, Skin Management, did not mention the frequency of skin assessments to be conducted by the facility.