STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675849	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOCUSED CARE AT BURNET BAY	3921 N MAIN BAYTOWN, TX 77521

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** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical and nursing needs that are identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans in that: -Resident #1's Care Plan did not have a focus, interventions, and goals for PICC line. This failure could affect residents with care plans and placed them at risk of receiving inappropriate care or having inaccurate care plans. The findings were: Record review of Resident #1's face sheet revealed Resident #1 was a [AGE] year old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's MDS assessment dated [DATE] revealed Resident #1 had a BIMS of 14, indicating no cognitive impairment. Resident #1 was receiving IV medications and [MEDICAL TREATMENT] while a resident at the facility. No documentation noted under [MEDICAL CONDITION] section on MDS. Record review of Resident #1's Physician order [REDACTED].PICC line dressing and Cap change weekly using sterile technique per protocol .Order date 03/29/2020 Record review of Resident #1's Care Plan dated 0[DATE]6/20 revealed Resident #1 did not have a Focus, Goal, or Interventions to address care of PICC line. Record review of Resident #1's MAR indicated [REDACTED].start date 03/27/20 . Observation on 04/25/2020 at 1:25 PM revealed Resident #1's PICC line dressing was dated 0[DATE]4/20, Dual port central catheter line noted over resident's left chest area. In an interview on 04/25/20 at 4:12 PM the MDS Nurse stated care plans were revised by the interdisciplinary teams (IDT). If the orders were to change or treatments changed then the IDT changes the care plan. In an interview on 04/25/20 at 4:25 PM the Administrator stated the nurses input the physician orders [REDACTED]. The nurse initiates the care plan, the DON and MDS Nurse review the care plan, and the IDT will review the plan and make changes. In an interview on 04/25/20 at 4:35 PM the DON stated the initial care plans were completed by the nurses, then she reviewed the plans and signed off on them in interdisciplinary meeting.
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, interview, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for 1 of 5 residents (Resident #1) reviewed for quality of care in that: Resident #1's PICC line dressing was not changed for 10 days. This failure could affect residents with a PICC line and placed them at risk for inadequate care, infections, or decline in health. Findings included: Record review of Resident #1's face sheet revealed Resident #1 was a [AGE] year old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS of 14, indicating no cognitve impairment. Resident #1 received IV medications and [MEDICAL TREATMENT] while a resident at the facility. Record review of Resident #1's Care Plan dated 0[DATE]6/20 revealed Resident #1 did not have a Focus, Goal, or Interventions to address care of PICC line. Record review of Resident #1's Care Plan dated 0[DATE]6/20 revealed Resident #1 was on the antibiotic [MEDICATION NAME] Solution. Staff were to give medications per order, monitor labs, cultures, report abnormal values to physician. Record review of Resident #1's Physician Orders dated 04/2020 revealed .PICC line dressing and Cap change weekly using sterile technique per protocol .Order date 03/29/2020 Record review of Resident #1's MAR / TAR dated 04/2020 revealed the document did not have a section to document the changing of Resident #1's PICC line dressing and cap weekly. Observation on 04/25/2020 at 1:25 PM revealed Resident #1's PICC line dressing was dated 0[DATE]4/20, Dual port central catheter line noted over resident's left chest area. In an interview on 04/25/20 at 1:25 PM Resident #1 stated the facility nursing staff did not change his dressing weekly. He said he had to stay on top of the nurses about his care. In an interview on 04/25/20 at 2:16 PM LVN A stated the nurses at the facility were responsible for changing Resident #1's PICC line dressing. She said the physician wrote the orders and puts them in the electronic record system or the nurse would receive the verbal order and put the verbal order into the system. She said documentation of treatments should be made on the TAR. In an interview on 04/25/20 at 3:25 PM LVN B stated the physician can enter an order into the system from home. She said if the orders were entered by the physician, then the nurse at the facility would have to verify the order. She said once it was verified, the order would transfer over to the TAR. She said Resident #1's dressing for PICC line should be changed every 7 days. She said all treatments should be documented on the TAR. In an interview on 04/25/20 at 3:37 PM the DON stated when the nurse received a verbal order from the physician they input that order into the system. She said if an order was entered into the system by the physician, the nurse at the facility would have to verify the order. She said the ADON would review the orders in the morning meeting from the previous day. She said currently, the ADON was out sick. She said the order for Resident #'1's PICC line should have transferred over to the TAR. She said she would have to investigate what happened. In an interview on 04/25/20 at 4:25 PM the Administrator stated the nurses input the physician orders into the system and the DON reviews the orders in the clinical meeting. In an interview on 04/25/20 at 4:35 PM the DON stated the order for Resident #1's PICC line dressing change did not transfer over to the TAR. She said the TAR would have triggered in the system for a treatment to be completed by the nurse. Record review of the facility policy Telephone Orders dated 02/2014 revealed .1. Verbal telephone orders may only be received by licensed personnel Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record Record review of the facility policy Dressings, Dry/Clean dated 09/2013 revealed . .1. Verify that there is a physician's order for this procedure . 2. Review the resident's care plan, current orders, and [DIAGNOSES REDACTED]. 3. Check the treatment record . .the following information should be recorded in the resident's medical record, treatment sheet or designated wound form: 1. the date and time the dressing was changed .3. The name and title (or initials) of the individual changing the dressing 9. The signature and title (or initials) of the person recording the data .
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health for 1 (Resident #1) of 5 residents reviewed for foot care. The facility failed to provide wound care on Resident #1's [MEDICAL CONDITION]. This failure could affect residents with wounds by placing them at risk for poor foot health, decreased personal hygiene, and a decline in their quality of life. Findings included: Record review of Resident #1's face sheet revealed Resident #1 was a [AGE] year old male that was admitted to the facility on [DATE] with

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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FOCUSED CARE AT BURNET BAY	**3921 N MAIN BAYTOWN, TX 77521**

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F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) [DIAGNOSES REDACTED]. Record review of Resident #1's TAR dated 03/2020 revealed Resident #1 [MED] Ointment 250 Unit/GM ([MEDICATION NAME]) Apply per additional directions topically every day shift for wound care for 30 days Start date 03/27/2020 . D/C date 0[DATE]7/2020 . . The TAR was missing documentation for wound care treatments on 03/27, 03/28, and 03/30. Record review of Resident #1's Admission assessment dated [DATE] revealed Resident #1 had a pressure ulcer on his left heel and no wound measurements were documented. Record review of Resident #1's MDS assessment dated [DATE] revealed Resident #1 had a BIMS of 14, indicating no cognitive impairment. Resident #1 was receiving IV medications and [MEDICAL TREATMENT] while a resident at the facility. No documentation noted under [MEDICAL CONDITION] section on MDS. Record review of Resident #1's Care Plan dated 0[DATE]6/20 revealed Resident #1 had a pressure ulcer/impaired skin integrity. Resident #1 was at risk for skin breakdown related to diabetes mellitus, immobility, incontinence, and physical impairment [MEDICAL CONDITION] to left mid foot. Staff were to assess skin weekly, treat as ordered, cleanse wound and apply calcium alginate daily. Record review of Resident #1's Physician Orders dated 04/2020 revealed [MED] Ointment 250 Unit/GM ([MEDICATION NAME]) Apply per additional directions topically every day shift for wound care for 30 days cleanse left lat. Mid foot with NS/wound cleanser, apply CalAlg cover with dry dressing Order date [DATE]7/2020 .end date 05/18/2020 . Record review of Resident #1's TAR dated 04/2020 revealed the document did not have a section to document the treatment of [REDACTED]. . The TAR was missing documentation for wound care treatments on 4/2, 4/4, 4/5, 4/6, 4/7, 4/8, 4/9, [DATE]1, [DATE]2, [DATE]3, [DATE]5, [DATE]6, and [DATE]7. Record review of Resident #1's Weekly Wound assessment dated [DATE] revealed Resident #'1 wound length was 1.2 cm, width 1.5 cm, and depth 0.1 cm. Resident had a diabetic wound on left mid foot. The wound bed was pink, the skin around wound was clear, the moist type tissue present was [MEDICATION NAME] tissue. Observation on 04/28/20 at 10:28 AM revealed Resident #1's left leg and foot noted without swelling. Resident able to move left lower extremity without discomfort. Left foot with 4x4 dry dressing over lateral aspect. Clean and dry dressing labeled 4/28/20 AM. Wound underneath dressing was exposed by LVN D and shown to surveyor. Calcium alginate overlaid the wound bed with scant to moderate amount of serosanguinous transudate without odor. Wound/ulcer approximate size was 5cms x 2 cms. Granulation tissue on wound edges noted. Dressing was replaced by nurse. LVN D doff gloves then washed hands with soap and water. LVN D said the dressing was changed daily and as needed depending on the amount of drainage. In an interview on 04/25/20 at 1:25 PM Resident #1 stated he missed a couple of days of wound care while at the facility. He said his foot started to get an odor and had slush. He said his wound got worse when he first came to the facility. He was worried because he did not want his foot to be amputated, he was diabetic. He said he had to stay on top of the nurses about his care. In an interview on 04/25/20 at 1:51 PM LVN C stated when treatments or medications were administered nursing staff were aware they were supposed to check off on the MAR / TAR. She said she did not complete wound care for Resident #1's foot today. She said the nurse that completed the wound care had to leave early. She did mention that there was nowhere to document on TAR that wound care was completed. In an interview on 04/25/20 at 2:16 PM LVN A stated documentation of treatments should be made on the TAR. The wound care nurse completed wound care for Resident #1. She said if the wound care nurse did not complete wound care, then the charge nurses were to complete the wound care. She said the physician wrote the orders and puts them in the electronic medical record system or the nurse would receive the verbal order and put the verbal order into the system. In an interview on 04/25/20 at 3:25 PM LVN B stated the physician can enter the order into the electronic medical record system from home. She said if the orders were entered by the physician, then the nurse at the facility would have to verify the order. Once it was verified the order would transfer over to the TAR. She was not sure if the physician order for [REDACTED]. If an order was entered into the system by the physician, the nurse at the facility would have to verify the order. She said the ADON would review the orders in the morning meeting from the previous day. She said the ADON was out sick. She said the order for Resident #'1's wound care should have transferred over to the TAR. She would have to investigate what happened. In an interview on 04/25/20 at 4:25 PM the Administrator stated the nurses input the physician orders into the system and the DON reviews the orders in the clinical meeting. She was not sure what happened to Resident #1's wound care orders because they discuss wound care in the clinical meeting and weekly standard of care meetings. In an interview on 04/25/20 at 4:35 PM the DON stated the order for Resident #1's wound care order for [DATE]7/20 did not transfer over to the TAR. She said the TAR would have triggered in system for a treatment to be completed by the nurse. She said the facility did not have a wound care nurse, now the charge nurses were doing the wound care. She said Resident #1 was admitted with a wound on to his left foot and he had been doing his own wound care at home. She said he had the wound for a long time. She said she saw his wound on Tuesday and did his wound care and it was fine. In an interview on 04/28/20 at 9:48 AM LVN D stated Resident #1's wound was getting better. She said when he first came to the facility the wound had yellow drainage. She said he would complain about not getting wound care during the morning and the nurse on the next shift would complete his wound care. She said Resident #1 would complain about the consistency of his wound care, but she believed he got wound care everyday it just was not always in the morning time. She said Resident #1's order was changed on 4/25/20- he is no longer treated with [MED] ointment. She said now the wound was treated with calcium alginate. Previously it was treated with [MED] and calcium alginate. In an interview on 04/28/20 at 10:51 AM Resident #1 stated he would go whole days without wound care. He said one time he missed wound care three days in a row. He said he could not remember the exact dates, but it was sometime at the beginning of April. Record review of the facility policy Dressings, Dry/Clean dated 09/2013 revealed . .1. Verify that there is a physician's order for this procedure . 2. Review the resident's care plan, current orders, and [DIAGNOSES REDACTED]. 3. Check the treatment record . .the following information should be recorded in the resident's medical record, treatment sheet or designated wound form: 1. the date and time the dressing was changed .3. The name and title (or initials) of the individual changing the dressing 9. The signature and title (or initials) of the person recording the data .
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 interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for clinical records, in that: -Resident #1's MAR and TAR had missing documentation for March and April 2020. -Resident #1's Initial Admission Assessment did not have wound measurements for diabetic ulcer to left foot. -Resident #1's Physician Orders were inaccurate for residents actual [MEDICAL TREATMENT] days. These failures could affect all residents and placed them at risk of incomplete clinical records. The findings were: Record review of Resident #1's face sheet revealed Resident #1 was a [AGE] year old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's MDS assessment dated [DATE] revealed Resident #1 had a BIMS of 14, indicating no cognitive impairment. Resident #1 was receiving IV medications and [MEDICAL TREATMENT] while a resident at the facility. No documentation noted under [MEDICAL CONDITION] section on MDS. Record review of Resident #1's Physician Orders dated 04/2020 revealed .PICC line dressing and Cap change weekly using sterile technique per protocol .Order date 03/29/2020 Record review of Resident #1's MAR / TAR dated 04/2020 revealed Resident #1 did not have a section to document the changing of Resident #1's PICC line dressing and cap weekly. Record review of Resident #1's TAR dated 04/2020 revealed Resident #1 [MED] Ointment 250 Unit/GM ([MEDICATION NAME]) Apply to per additional directions topically every day shift for wound care for 30 days Start date 03/27/2020 . D/C date 0[DATE]7/2020 . . The TAR was missing documentation for wound care treatments on 4/2, 4/4, 4/5, 4/6, 4/7, 4/8, 4/9, [DATE]1, [DATE]2, [DATE]3, [DATE]5, [DATE]6, and [DATE]7. Record review of Resident #1's TAR dated 03/2020 revealed Resident #1 [MED] Ointment 250 Unit/GM ([MEDICATION NAME]) Apply to per additional directions topically every day shift for wound care for 30 days Start date 03/27/2020 . D/C date 0[DATE]7/2020 . . The TAR was missing documentation for wound care treatments on 03/27, 03/28, and 03/30. Record review of Resident #1's Admission assessment dated [DATE] revealed Resident #1 had a pressure ulcer on his left heel no wound measurements were documented. Record review of Resident #1's MAR dated 04/2020 revealed .[MEDICATION NAME]-[MEDICATION NAME] Solution Reconstituted 2-5 GM-% (50ML) Use 2 gram intravenously one time a day for infection for 34 days . Resident #1 had missing documentation for treatment on 4/6, 4/8, [DATE]3, [DATE]4, and 4/22. Record review of Resident #1's Physician Orders dated 04/2020 revealed Resident to attend [MEDICAL TREATMENT] on T_TH_Sat days with chair time of every evening shift every Tues, Thu, Sat for [MEDICAL CONDITION] Record review of Resident #1's Care Plan dated [DATE]4/20 revealed Resident #1 needs [MEDICAL TREATMENT] ([MEDICAL TREATMENT]) related to [MEDICAL CONDITION] Encourage Resident #1 to go for the scheduled [MEDICAL TREATMENT] appointments. Resident receives [MEDICAL TREATMENT] (M-W-F) at . [MEDICAL TREATMENT] . . Observation on

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) 04/25/2020 at 1:25 PM revealed Resident #1's PICC line dressing was dated 0[DATE]4/20, Dual port central catheter line noted over resident's left chest area. Observation on 04/28/20 at 10:28 AM revealed Resident #1's left leg and foot noted without swelling. Resident able to move left lower extremity without discomfort. Left foot with 4x4 dry dressing over lateral aspect. Clean and dry dressing labelled 4/28/20 AM. Wound underneath dressing was exposed by LVN D and shown to surveyor. Calcium alginate overlaid the wound bed with scant to moderate amount of serosanguinous transudate without odor. Wound/ulcer approximate size was 5cms x 2 cms. Granulation tissue on wound edges noted. Dressing was replaced by nurse. LVN D doff gloves then washed hands with soap and water. LVN D said the dressing was changed daily and as needed depending on the amount of drainage. In an interview on 04/25/20 at 2:16 PM LVN A stated the nurses at the facility were responsible for changing Resident #1's PICC line dressing. She said the physician wrote the orders and puts them in the electronic record system or the nurse would receive the verbal order and put the verbal order into the system. She said documentation of treatments should be made on the TAR. In an interview on 04/25/20 at 3:25 PM LVN B stated the physician can enter an order into the system from home. She said if the orders were entered by the physician, then the nurse at the facility would have to verify the order. She said once it was verified, the order would transfer over to the TAR. She said Resident #1's dressing for PICC line should be changed every 7 days. She said all treatments should be documented on the TAR. In an interview on 04/25/20 at 3:37 PM the DON stated when the nurse received a verbal order from the physician they input that order into the system. She said if an order was entered into the system by the physician, the nurse at the facility would have to verify the order. She said the ADON would review the orders in the morning meeting from the previous day. She said currently, the ADON was out sick. She said the order for Resident #'1's PICC line and wound care should have transferred over to the TAR. She said she would have to investigate what happened. In an interview on 04/25/20 at 4:25 PM the Administrator stated the nurses input the physician orders into the system and the DON reviews the orders in the clinical meeting. The nurse initiates the care plan, the DON and MDS Nurse review the care plan, and the IDT will review the plan and make changes. In an interview on 04/25/20 at 4:35 PM the DON stated the order for Resident #1's PICC line dressing change did not transfer over to the TAR. She said the order for Resident #'1's wound care should have transfer over to the TAR. She said the TAR would have triggered in system for a treatment to be completed by the nurse. She further stated Resident #1's [MEDICAL TREATMENT] days were changed he no longer goes on Tuesday, Thursday, Saturday. Resident wanted to switch days. She said the Physician Orders were not changed. The initial care plans were completed by the nurses, then she reviewed the plans and signed off on them in interdisciplinary meeting. Record review of the facility policy Charting Errors and/or Omission dated 12/2006 revealed .Policy Statement Accurate medical records shall be maintained by this facility Policy Interpretation and Implementation .1. If an error is made while recording the data in the medical record, line through the error with a single line and correct the error .