STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675386	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHISPERING PINES LODGE	**2131 ALPINE RD LONGVIEW, TX 75601**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 interview and record review, the facility failed to ensure treatment and care, in accordance with the comprehensive care plan and professional standards of practice was provided for 1 of 3 residents reviewed for quality of care. (Resident #1) The facility did not follow physician orders [REDACTED]. This failure could place residents at risk for not receiving care and services to meet their needs. Findings included: A face sheet dated 07/30/20 indicated Resident #1 was [AGE] years old and admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was discharged to a local hospital on [DATE]. An MDS (Minimum Data Set) dated 05/26/20 indicated Resident #1 sometimes made her needs known, usually understood others, and had moderately impaired cognition. She required extensive 2-person assistance with ADLs. Resident #1 had an indwelling catheter and her bowel continence was not rated. Resident #1 had a stage 4 pressure injury upon admission. A physician order [REDACTED].#1 included an indwelling catheter to gravity drainage for stage 4 press injury, empty catheter drainage bag and provide catheter care every shift, monitor catheter for leakage, blockage, sediment buildup, or low output, ensure catheter bag was in a privacy bag while in bed or wheelchair, and ensure catheter strap was in place and holding. A nursing note dated 07/12/20 at 6:49 p.m. indicated the day shift and night shift nurse attempted to change Resident #1's indwelling catheter due to it leaking. Resident #1 complained of discomfort during removal of the catheter. A new catheter was inserted with no urine return. The nurse attempted to reposition the catheter and blood was noted on the catheter. Resident #1's physician was notified and ordered for the catheter to be left out for now. A care plan dated 07/28/20 indicated Resident #1 had a pressure injury to her sacrum and right hip. Resident #1 was non-compliant with treatment and would scratch at her skin and remove the dressing. Interventions included to provide treatments as ordered, administer medications as ordered, and provide incontinent care after each incontinent episode and apply barrier cream. Resident #1 had an indwelling catheter and staff should change the catheter as ordered, ensure the tubing was anchored, and document any discomfort due to the catheter. Medication Administration Records (MAR) dated July 2020 indicated staff initialed that Resident #1 was provided catheter care every shift, the catheter to gravity drainage, the drainage bag was emptied, the catheter strap was in place and holding, staff monitored for leakage, blockage, sediment buildup, and low output, and the catheter was in a privacy bag while the resident was out of bed on the following days: *once on 07/14/20; *twice on 07/15/20; *twice on 07/16/20; *once on 07/17/20; *once on 07/20/20; *once on 07/21/20; *twice on 07/22/20; *once on 07/23/20. A physician order [REDACTED].#1 discontinued an indwelling catheter to gravity drainage, empty catheter drainage bag and provide catheter care every shift, monitor catheter for leakage, blockage, sediment buildup, or low output, ensure catheter bag was in a privacy bag while in bed or wheelchair, and ensure catheter strap was in place and holding. A physician order [REDACTED].#1 included an indwelling catheter to gravity drainage, empty catheter drainage bag and provide catheter care every shift, monitor catheter for leakage, blockage, sediment buildup, or low output, ensure catheter bag was in a privacy bag while in bed or wheelchair, and ensure catheter strap was in place and holding. A nursing note dated 07/24/20 at 8:14 a.m., written by LVN A indicated Resident #1 was sent to a local hospital for decreased level of consciousness and a finger stick blood sugar of over 600. During an interview on 07/29/20 at 2:46 p.m., LVN A said at the end of his shift on 07/12/20 he assisted LVN B with changing Resident #1's indwelling catheter due to leakage. He said when they inserted the new catheter, there was no urine return but they observed blood on the catheter. He said LVN B called Resident #1's physician and notified him of Resident #1's response to the catheter. He said the physician told LVN B to leave the indwelling catheter out for a while. He said the orders should have been discontinued and staff should not have been initialing that they were providing catheter care. During an interview on 07/29/20 at 5:27 p.m., LVN B said on 07/12/20, she and LVN A attempted to change Resident #1's indwelling catheter because it was leaking. She said the catheter came out with no issues. She said when they attempted to insert the new catheter there was no urine return. LVN B said she observed sediment and bloody discharge and Resident #1 complained of discomfort. She said she called Resident #1's physician and was told to leave the catheter out for now. LVN B said the physician did not discontinue the catheter order. She said she did not insert a new catheter because the facility did not have anymore 18 French catheters. She said the facility ordered more catheters, but they had not been received. LVN B said staff should have not initialed that catheter care was performed when Resident #1 did not have an indwelling catheter. During an interview on 07/30/20 at 11:15 a.m., Resident #1's wound physician said she had weekly virtual telehealth visits with Resident #1 and assessed her wounds each week. She said she last saw Resident #1's wounds on 07/23/20. She said Resident #1 had multiple comorbidities and Resident #1's wounds were more likely unavoidable due to her deterioration in health. She said she leaned more to not using indwelling catheters and preferred catheters to be used for a minimal amount of time. During an interview on 07/30/20 at 12:31 p.m., Resident #1's physician said Resident #1 admitted to the facility with a stage 4 wound and the resident was non-compliant with care. He said she would scratch at her skin and removing the dressing over her wound. He said she last saw Resident #1 a few weeks ago and she refused to speak to him and was refusing medications from staff. He said based on Resident #1's health decline and comorbidities, her wounds were unavoidable. He said he was notified by the facility that staff were unable to get urine return when they inserted Resident #1's indwelling catheter. He said he told the nurse to leave the catheter out and attempt to insert another catheter at a later time. He said he expected staff to attempt to insert a new catheter within a few days and Resident #1's indwelling catheter orders should have been discontinued at that time. During an interview on 07/30/20 at 11:44 a.m., the DON said Resident #1 admitted with an indwelling catheter due to a stage 4 pressure injury. She said staff attempted to replace Resident #1's indwelling catheter on 07/12/20 due to trauma from the resident pulling out the catheter. She said nursing staff were unable to successfully replace the catheter. She said staff should not have signed off that they provided catheter care when the resident did not have a catheter. She said staff should have documented the orders were on hold. The DON said the medical records staff member normally ordered their indwelling catheters. She said the medical records staff member was terminated and another staff member ordered the catheters but the sheet that included Resident #1's catheters did not get sent. She said they did finally get the order to the supplier and received the correct size catheters. A supply invoice dated 07/28/20 indicated 5 boxes of 18 French indwelling catheters were ordered on [DATE] and shipped to the facility on [DATE]. The facility's catheter policy dated 02/13/07 indicated to change the catheter and drainage system as needed unless ordered otherwise by the physician.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE