STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676068	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST TEXAS LTC PARTNERS INC	**1915 GREENWOOD ST SAN ANGELO, TX 76901**

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure prompt efforts to resolve grievances for 1 of 20 (Resident #16) residents reviewed for resident rights. The facility did not promptly resolve multiple grievances for Resident #16 that included nutrition, hydration, and wound care. This failure placed residents at risk of unresolved grievances, and at risk for a decreased quality of life. Findings included: Record review of Resident #16 Admission Record (Face Sheet) indicated an [AGE] year-old female with an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's Quarterly MDS dated [DATE] indicated severely impaired cognition and extensive assist of one person for ADLs. Resident #16 was identified as having weight loss of 5% or more in the last month or 10% in last 6 months. No swallowing disorder was identified. Resident #16 was identified to have Moisture associated Skin Damage (MASD). Record review of an email concern dated 4/28/20 from RP B provided by Ombudsman indicated the following for Resident #16 that was sent to Administrator, DON, and MDS Coordinator: Email dated 4/28/20 Saturday, April 25th, I received a call from a nurse at Nursing Home. The nurse told me that my mother, had rolled out of bed and fallen on bedside safety mat that was put there for that purpose (She has fallen from her bed before). She told me my mother was ok, her vitals were good and there didn't seem to be any bruising. I asked if they might be able to do an x-ray, just to check for rib fractures and such. The nurse told me that was not necessary since she fell on the mat. My mother cannot speak very clearly and is not able to say if something is hurting or if she feels pain anywhere, I am just concerned she might be in pain and not able to say she is. What I am requesting is a copy of the incident report that was done on mother's fall that day. Also, on Tuesday, April 20th, the DON called me and told me my mother had a sore on her bottom. She said they would be keeping an eye on it so it wouldn't get worse or infected. I asked the nurse on Saturday how mother's sore was doing and she told me it was a slow process and they were keeping it dry and clean. I am also requesting a photo (if possible and able to) of my mother's sore. For my peace of mind, I need to see that it is healing. I would appreciate if someone can do this for me. Record Review of email response from Administrator dated 5/4/20 provided by Ombudsman indicated the following for Resident #16: Please forgive my delayed response. I'm not able to release a copy of the actual incident report. Those are part of our QA process and not part of the medical record. What I can give you is any nurses notes that pertain to the incident in question. Would you like me to just mail them to you? Also a picture of the wound is fine. I'm afraid it may serve only to upset you, but I can ask the DON to send you a picture of it no problem. Again, I apologize for not getting back to you sooner. Record review of emails provided by DON of pictures of wound emailed to daughter indicated the following dates: 5/13/20- emailed picture with comment from DON that said it looks the same, a little better, its healing very slowly. We changed the treatment order yesterday. 6/4/20- The wound continues to improve, its looking really good. Her weight is stable at 123.8 Record review of email from RP B dated 7/6/20 that was sent to the DON and MDS Coordinator indicated the following for Resident #16: This will be my 3rd email that I have sent to the DON requesting an update on my Mother's (Resident #16) sore and her weight. I sent one on the 18th of June and on the 23rd of June. I still yet to get a reply. So again, can I please have an update on her sore and weight. She is still complaining about pain on her bottom when we visit. Another thing I need to stress is that Mother needs to be offered water every 2 hours or so. We visited one day and the med aide, went to give Mother her 4 o'clock pill. After Mother took her pill and drank quite a bit of water, she said, Thank you for the water, I have not had any water today. That was very hard to listen to. It made my Father and I very sad. I have called and sent grievances about the water issue, but the response is that the residents are offered water every couple of hours. I have no way of knowing if water is offered to Mother or not. All I can do is pray for our Mother's wellbeing. I hope that your staff will continue to do the best they can to make sure all the residents are being treated with dignity and respect. No grievance report was provided by the facility related to the email. Record review of facility nurse email response for 7/6/20 provided by Ombudsman indicated the following for Resident #16: Her weight is currently 116.2. On 6/10 she was 119.2. As far as the sore, I will have to let the DON answer. I have not seen it. Record review of Resident #16's nurse's note (late entry entered 7/15/20 for 7/12/20) indicated the following: Daughter for Resident #16 came to see resident at front door window informed of continued weight loss even with appetite stimulant resident holding food in her mouth and spitting it out at times other times will eat with no problem daughter stated she understands her mother is declining and felt it was due to visitor restrictions for covid. Record review of DON email response dated 7/17/20 for Resident #16 provided by Ombudsman indicated the following: I apologize, I am just now seeing your email. I have been working on the floor lately and had not had a chance to comb through them. Surprisingly, her wound is progressing. We have tried everything we can think of because she continues to lose weight, including changing her diet to a fortified diet, we have also tried a couple of different appetite stimulants, she continues on [MEDICATION NAME] at this time. She eats well at times and at other times she wants nothing at all. She will hold her mouth closed or spit the food/drink out. I have sat with her several times and assisted her. I have spoken to RP B on Sun 7/12, I informed her of all of this, of the wound status and of the continued weight loss, at that time, her daughter voiced that she understood her mother is declining and asked that we continue to try and do what we do. Resident #16 is [AGE] years old and has severe dementia. we will continue to assist her at meals, offer fluids, and monitor treat her wound. Thank you, again I apologize for the delay. No grievance report was provided by the facility related to the email. During an interview with RP A on 8/12/20 at 2:01 pm, she said the facility did address her concerns but took a long time and many complaints for them to do what they were supposed to. She said her mother continues to lose weight and was at 110 pounds last update she received from the facility. She said she had not received a new picture of her mother's wounds as requested but to her the wound was the same and not improving but could not check because of the restricted visitation related to Covid-19. She said that they had informed her of a change from mechanical soft and regular liquid to pureed and nectar thick liquids and she had agreed. She said she had been requesting a picture of her mother's wound since July 6th but had not received the picture as requested as of today 8/12/20. She said she did not receive a copy of the Grievance/Complaint report from the facility. Record review of Resident #16's Weekly skin assessment for 8/3/20 and 8/10/20 indicated no changes with a measurement of 0.5 cm. The wound was identified as Moisture associated Skin Damage (MASD). During an interview with Ombudsman B on 8/12/20 at 9:34 am, she said that she had been in contact with RP A related to Resident #16, related to slow response times for grievances. She said the facility eventually responded to the concerns but were not addressed promptly. She said the concerns were addressed after several days or longer. She said the administrator and RP A would communicate back and forth via email and in person. She said she would forward email communications between RP A, the facility, and Ombudsman B. During an interview with the Administrator on 8/14/20 at 10:44 am, he said that the DON had sent the daughter pictures of the wound and would have her provide the emailed picture dates that she had requested 4/28/20. He said that he had asked her what he could do to prove

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the concerns she had voiced were addressed but she had a firm belief that staff lied to her and did not believe the concerns were being addressed. He said he did not provide a copy of the grievance report to the daughter upon completion. Record review of the facility's Filing Grievance/Complaints Policy with a revision date of December 2004 indicated the following: 5. Upon receipt of written grievance and/or complaint, _____ (blank was left empty) will investigate the allegations and submit a written report of such findings to the administrator within ____ (blank was left empty) working days of receiving the grievance and/or complaint. 7. The resident, or person filing the grievance and/or complaint in behalf of the resident, will be informed of the finding of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the Administrator, or his designee, within ____ (blank was left empty) working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the resident, and a copy will be filed in the business office. Record review of the Investigation Grievances/Complaints Policy with a revised date of December 2004 indicated the following: 4. The resident or person acting in behalf of the resident will be informed of the findings of the investigation, as well as any corrective actions recommended within ____ (blank was left empty) working days of the filing of the grievance complaint. Record review of the Grievance/Complaint Log with a revised date of December 2004 indicated the following: 3. f. The date the resident, or interested party, was informed of the findings .
F 0805 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 20 residents (Resident #2) reviewed for meals in that: Resident #16 was served corn bread, mechanical soft pork, and potatoes instead of pureed and regular ice tea instead of nectar thick. These deficient practices could affect residents by placing them at risk for choking and weight loss. The findings were: Record review of Resident #16 Admission Record (Face Sheet) indicated an [AGE] year-old female with an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's Quarterly MDS dated [DATE] indicated severely impaired cognition and extensive assist of one person for ADLs. Resident #16 was identified as having weight loss of 5% or more in the last month or 10% in last 6 months. No swallowing disorder was identified. Record review of Resident #16's Care Plan with a revision date of 8/14/20 indicated: Focus Diet: 8/11/20- Pureed texture, nectar consistency liquids . Interventions/Tasks Provide, serve Resident #16 her diet as ordered . Record review of Resident #16's nurses notes indicated the following: 7/15/20- . Also informed daughter of continued weight loss she voiced understanding and stated to continue to try to encourage her to eat and drink. Resident noted to be holding food in her mouth and then spitting out. 8/8/20- Attempted to assist with noon meal for 45 mins. She was pocketing the chicken in her cheeks. She chewed repeatedly. She drank a health shake and ate of veggies and potatoes. She drank 4 ounces of water. She began to say no and clamped teeth on spoon. Assisting with meal stopped. She continued to chew on chicken still in mouth. She then began to pull chicken from her mouth with her hands . 8/9/20 (late entry for 8/8/20) Spoke with daughter regarding difficulty with meal and new order for Speech Therapy to eval and treat. She is in agreement . Discussed progression of dementia and the decreased memory of how to swallow. Discussed changing diet to pureed so she doesn't have to try to chew as much since her dentition is poor. Daughter agrees to downgrade. Record review of Resident #16's Order Summary Report (Consolidated MD Orders) the following ordered was noted: Regular diet Pureed texture, Nectar consistency for difficulty swallowing, chewing with a start date of 8/11/20. During an observation on 8/12/20 at 12:50 pm, on Resident #16's plate had corn bread, mechanical soft pork, mechanical soft fries, and regular consistency ice tea. During an interview with CNA C on 8/12/20 at 12:33 pm, she verified food on Resident #16's plate was mechanical soft with regular liquid. During a follow up interview with CNA C on 8/12/20 at 1:41 pm, she said that she was familiar with Resident #16. She said that the resident has good and bad days for feeding assist but said that she prefers to start off feeding herself and if you try to help her too early she gets annoyed and refuses to eat. She said today she ate a little less than 50% and that she is offered a shake when she eats 25-50% which is monitored for each meal in the kiosk. She said there was a check off on some residents when they eat less than 50%. She said she was aware that the resident had been losing weight and that the weight loss seemed to have gotten worse after the pandemic started. She said intake and identified weight changes are reported to the nurse for follow up. She said she was not aware the resident had been changed to pureed and nectar thick diet and that Resident #16's slip said mechanical soft when she reviewed the slip. Record review of Resident #16's Diet Slip dated 8/12/20 indicated the following: Regular/Mechanical Soft Beverage Texture Regular During an interview with the DON on 8/12/20 at 1:00 pm, she verified new orders were given yesterday 8/11/20 for pureed and nectar thick liquid for Resident #16. She said resident had a history of [REDACTED]. She said that usually during morning meeting orders are checked but the morning meeting was not conducted that day because of the visit from the state surveyor so the new diet order was missed per Speech Therapy recommendations for changes. She said if morning meeting had been conducted she would have provided dietary with the new order for pureed and nectar thick liquid diet. During an interview with the Dietary Manager on 8/12/20 at 1:30 pm, she said that she had been at the facility for about 2 weeks and had forgot to update the new recommendations from the Speech Therapy for the changed diet to puree and nectar thick for Resident #16. She said the diet slip should have been updated yesterday (8/11/20) so the changes would have been reflected on the diet slip that her cook followed today (8/12/20). During an observation on 8/14/20 at 12:15 pm, Jug of water in room of Resident #16 with regular consistency water. During an interview with CNA D on 8/14/20 at 12:26 pm, she said she was aware the resident had weight loss and hydration rounds are conducted on her every 2 hours and that she received regular liquids and verified the jug that was bed side had regular consistency water in it. She said she was not aware of any changes to the resident's diet. During an interview with the DON on 8/14/20 at 12:39 pm, she confirmed there was regular water in Resident #16's jug and said she had spoken to staff this morning about the diet changes to Resident #16 and was not sure why she had regular consistency liquid in her jug. During an interview with SLP E on 8/14/20 at 12:54 pm, she said that she had picked up Resident #16 under physician orders [REDACTED]. She said during her assessment she was pooling and drooling so she made the recommendation to down grade texture to pureed and liquids to nectar. She said the DON told her that staff had not followed through with the recommendations. She said yesterday 8/13/20 she was doing better and had trialed her with regular coffee and had done fine during the trial but had not recommended any changes to upgrade diet or liquids. She said she had given paper work to dietary and nursing related to the recommendations but unfortunately the recommendations had not been followed through. Record review of the facility's Interdepartmental Notification of Diet (Including Changes and Reports) Policy last revised April 2006 indicated the following: Nursing Services shall notify the Department of a resident's diet orders, including any changes in the resident's diet, meal service, and food preferences. 1. When a new resident is admitted , or a diet has been changed, the Nurse Supervisor shall ensure that the Food Services Department receives a written notice of the diet order. The dietary Department will also be notified verbally if the diet change or report occurs one hour or less before a scheduled meal, or if circumstances indicate that the written procedures will be be adequate to ensure service at the next meal.