STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. BUILDING _____ B. WING _____	**07/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE LTC PARTNERS INC	**1621 BUTLER DIMMITT, TX 79027**

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 0684 **Level of harm -** Immediate jeopardy **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 interviews and record review, it was determined the facility failed to ensure that residents received treatment and care in accordance with the professional standards of practice and comprehensive person-centered care plan for 1 of 7 residents (Resident #1) reviewed for care provided. The facility failed to ensure Resident #1 was properly assessed and received intervention for a new left AKA and surgical incision. Resident #1 arrived at her physician to have the stump evaluated and sutures removed. The physician found the incision had dehisced (opened up), had purulent drainage and had necrotic tissue around the skin edge. This resulted in Resident #1 being sent to the hospital and having surgery the next day for further amputation (removing tissue, muscle and bone to the amputation site. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 7/8/2020 at 4:20 p.m. While the IJ was lowered on 7/10/2020 at 12:25 p.m., the facility remained out of compliance at a level of actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. The Administrator was notified on 7/9/2020 at 11:00 a.m. of the acceptance of plan of removal and the Immediate Jeopardy was lowered. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition, the need for hospitalization or death. The evidence is as follows: Record review of Resident #1's clinical record revealed she admitted to the facility on [DATE], was [AGE] years old with the following Diagnoses: [REDACTED]. -A Medicare 5-day/Admission MDS resident assessment, dated 6/3/2020, documented the resident scored 13 of 15 on a mini-mental exam, required extensive assistance by one staff for locomotion in her room, requires limited assistance by one staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing, limited range of motion of one lower extremity, uses a wheelchair, occasionally incontinent of bladder, 62 inches tall and 159 pounds, surgical wound and surgical wound care. - Physician order [REDACTED].#1 up from the hospital on [DATE] when she was admitted . CNA A stated she took Resident #1 to her check-up at her doctor's office on 6/11/2020 and the doctor said he needed to clean out the wound because it was not healing well. During an interview on 6/19/2020 at 1:20 p.m., LVN B stated she had taken care of Resident #1 on the 1st or second day that she was in the facility. LVN B stated Resident #1's stiches were intact and the AKA was bleeding so she cleaned it up and wrapped it up. LVN B stated Resident #1's stump did not smell but was bloody and she had to change the dressing twice that night. During an interview on 6/19/2020 at 1:40 p.m., LVN C stated Resident #1 was not having any problems with her AKA. LVN C stated Resident #1's stump was draining in the middle but there was no odor or redness and it was not hot to touch. LVN C stated Resident #1 showered the night before she went to the doctor (6/10/2020). LVN C stated Resident #1's AKA looked good when she dressed it the night before she went to the doctor and she was not running a fever and her stump did not smell. LVN C stated she had taken care of Resident #1 for the three days before she went to the doctor. LVN C stated the day before Resident #1 went to the doctor, PT had informed her that Resident #1 had taken off her dressing while he was working with her. LVN C stated she had Resident #1 showered and she redressed her stump the night before her doctor's appointment and the stump did not have any signs of infection at that time. During an interview on 6/19/2020 at 2:10 p.m., the Administrator stated Resident #1's AKA did not smell when she left the facility to see her doctor to have the staples removed. The Administrator stated he had checked on Resident #1 on a daily basis and that was impossible that her AKA smelled at all because someone would have noticed that. The Administrator stated Resident #1's sons came to the facility and wanted information about their mother because they said the facility did not take care of her. The Administrator stated Resident #1's sons said they wanted to sue the facility so he gave them the 1-800 number to call State. The Administrator stated Resident #1 still had staples in her surgical wound and staff were doing vitals on all residents two to three times a day and they would have known if Resident #1 had an infection. The Administrator stated he was a nurse too and Resident #1's AKA was not infected. The Administrator stated he watched them do treatments on Resident #1 and she was fine. (Per the doctor's hospital records, Resident #1 had sutures in her stump, not staples) During an interview on 6/19/2020 at 3:00 p.m., the NP for Resident #1's physician stated she had discharged Resident #1 from the hospital today (6/19/2020) but she did not know what her AKA looked like when she arrived at the doctor's office. NP stated she had only seen Resident #1 once and she did have some drainage from her wound but advised to contact the doctor after the weekend to get a better picture of how Resident #1's AKA looked when she arrived at the doctor's office. During an interview on 6/19/2020 at 3:30 p.m., the PT stated he had been working with Resident #1 for a while and she was good at participating. PT stated he was supposed to do a home assessment for Resident #1 after her doctor's appointment on 6/11/2020 but she ended up going to the hospital. PT stated the day before Resident #1 went to her doctor, her dressing was not staying on very well so they were talking about doing her home assessment and all that would include. PT stated during this conversation with Resident #1, she kept messing with her dressing and finally pulled the dressing off. PT stated when he saw Resident #1's surgical incision (on 6/10/2020), it just did not look good at all to him. PT stated Resident #1's surgical incision looked like it was possibly infected and had some necrotic tissue on the incision itself. PT stated he was not a nurse but Resident #1's incision did not look good. PT stated he told the nurse about Resident #1's incision and she was taken to the shower to clean her up and that was the last time he saw her. PT stated he was aware Resident #1 was going to see her doctor the next day so he was not too concerned. During an interview on 6/19/2020 at 4:00 p.m., the Administrator was asked if there were any weekly skin assessments for Resident #1 and he found one assessment. Review of an Admission/Readmission Assessment, dated 6/2/2020, documented under Skin Integrity that Resident #1's skin was normal, warm and dry, and had the following: a. a bruise but did not note location or measurements b. skin tears but did not note location or measurements c. an abrasion but did not note location or measurements d. laceration but did not note location or measurements e. surgical incision but did not note location or measurements f. rash but did not note the location g. moisture associated skin damage but did not note location or measurements h. checked yes that resident had a pressure, venous, arterial, or diabetic ulcer. This document was signed by the corporate nurse NOTE: A Nursing Progress Note by the corporate nurse, dated 7/8/2020, documented the following: Late entry: on admission assessment, everything under skin was checked yes, the only thing that she (Resident #1) had was surgical incision. Review of a Weekly Skin Assessment, dated 6/7/2020, documented Resident #1 had a surgical incision of left aka but it failed to have a description of the incision site, what it looked like and how many sutures or staples the incision had. This document was signed by the corporate nurse. Reviewed Daily Skilled Nursing Assessments, dated 5/29/202, 5/30/2020, 6/3/2020, 6/8/2020 and 6/11/2020, failed to document the condition of Resident #1's surgical incision or a description of the incision or how many staples/stiches were in place. During an confidential interview on 6/22/20 at 12:30 p.m., CI 1 stated the facility did not take care of his mother like they should have. CI stated her physician said the AKA was infected and smelled like a dog and even her blankets had a smell. CI 1 said her AKA was only cleaned and dressed three to four times. CI 1 stated she had to have more

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 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) surgery on her leg. CI 1 stated the family thought Resident #1 was coming home the day she went to the doctor (6/11/2020) but her incision was infected and they had to do surgery on it again. During an interview on 7/8/20 at 3:20 p.m., Resident #1's orthopedic surgeon stated if staff at the nursing home were looking at the incision daily, the incision was not probably checked on properly. Resident #1's physician stated the incision site did not get that way over night. Resident #1's physician stated that someone should have noticed a change in the incision at least a few days before she came to his office on 6/11/2020. During an interview on 7/8/2020 at 3:40 p.m., Resident #1's NP stated she looked at Resident #1's incision on 6/9/2020. Resident #1's NP stated she remembered Resident #1 because her dressing was coming off but there was no redness or drainage. When asked if she observed the whole incision cite, Resident #1's NP stated no, Resident #1's dressing was coming off and she just looked at the part that was sticking out of the dressing. Resident #1's NP stated she looked at about 1/3 of the incision. During an interview on 7/10/2020 at 10:50 a.m., RN D stated she changed Resident #1's dressing on 6/11/2020 before she left the facility to go to her doctor's appointment. RN D stated Resident #1's incision did not have any redness, was not hot, there was no puss and there was no drainage. RN D stated she cleaned the incision with normal saline, dried it and then dressed Resident #1's incision. RN D stated she did not notice anything unusual about Resident #1's incision. Doctor's records for Resident #1 Review of a fax received from Resident #1's orthopedic surgeon on 6/23/2020, documented the following findings: Patient presents today, 6/11/2020, post op of left aka. Patient states she is in pain today. 8/10. Has some gross drainage but denies nausea, vomiting, fevers or chills. Physical exam of left AKA stump - dehiscence (incision opened up) with necrosis about the lateral edge. Will admit to the hospital and start on [MEDICATION NAME] antibiotics plan and take patient for surgical irrigation debridement - likely wound VAC placement. Surgery date 6/12/2020: preoperative Diagnosis: [REDACTED]. Procedure performed: left above-knee amputation, incision and drainage, 15 x 6 cm, excisional (remove) skin, subcutaneous tissue, bone and muscle. Cultures taken. Wound VAC placement. Surgery dated 6/16/2020: preoperative Diagnoses: [REDACTED]. Cultures taken. Secondary wound closure. The Administrator was notified of an Immediate Jeopardy (IJ) on 7/8/2020 at 4:20 p.m. On 7/9/2020 at 9:40 a.m., the facility provided a plan of removal and it was accepted on 7/9/2020 at 11:00 a.m. It documented the following: Plan of Removal for Immediate Jeopardy for F 684 Quality of Care Please accept this letter as plan to remove the Immediate Jeopardy cited on 7/8/2020. On 7/8/2020, the following residents received a head to toe assessment by Director of Nurses: the two residents with current orders for wound treatment. (Resident #5 and #6) were assessed and the Primary Care Physician and NP were notified and ordered for facility to continue with current treatment orders for the two residents. In-Service started with RN/LVN's by the Director of Nurses on Quick Reference-Topical Wound Tool and completion of skin assessments weekly. In-Service also completed by Regional Clinical Director to Administrator and Director of Nurses to ensure Weekly Skin Assessments are completed, accurate and MD orders are followed weekly. All new or re-admissions will receive a Skin Assessment within 12 hours of admission and Director of Nurses will review Point Click Care to ensure the Skin Assessment was completed timely. Wound status baseline from initial assessment will be reviewed to compare wound status to current status. RN/LVNs will receive education on when to notify facility/physician if there are any significant changes to the wound if worsening. Staff will follow Point Click Care Skin and document skin color, temp of skin, skin turgor assessment, location of skin and moisture. Administrator and Director of Nurses will review all skin issues on a weekly basis during facility Standards of Care Meetings to include progress or worsening of wound and update care plan as necessary, and any issues identified will be corrected and reviewed with Quality Assurance Committee. 35 current residents were listed. All residents identified to be at risk for skin breakdown were assessed for any skin breakdown on 7/8/2020 and documented. No new skin issues were identified other than the two residents currently receiving treatments. The facility Medical Director was notified on 7/8/2020 of facility action plan and to offer any suggestions. This plan was implemented 7/8/2020. This action plan will be monitored through personal observation by the Administrator on a daily basis during facility IDT Meeting by record review and verbal reports to the Regional Director of Operations. On 7/10/2020 starting at 10:00 a.m., interviews with four nurses working and the Administrator revealed all nursing staff in the building had been in-serviced on how to assess a wound and document appropriately in the clinical record. In addition, staff knew when to notify a physician if there were any significant changes to a wound and documenting findings in Point Click Care. Monitoring of nursing notes and Point Click Care was on-going. Record review on 7/10/2020 at 11:00 a.m. revealed all nursing staff were given a picture of a wound on 7/8/2020 and each nurse had to decribe the wound as if they were entering a nurses note. Documentation of each wound was properly written, The facility had conducted the following in-services with all nursing staff: 6/19/2020 - It is the charge nurse's responsibility to do head to toe assessment and do proper documentation. Wound site, odor, drainage, color of wound and pain level for example. If an aide or any other staff report to the charge nurse anything, it is the charge nurse's responsibility to follow up, and notify the MD/FNP, the family, the DON and the Administrator. Change of conditions can occur quickly. Do not wait for an appointment or the next shift to at least look at it. Documentation is imperative to resident's care. If it is not documented equal it didn't happen. 7/8/2020 - Need to notify MD/FNP if notice any of the following on a wound: redness, excessive drainage, foul odor, increased pain, worsened in size, and/or new eschar/slough present. 7/8/2020 - Assessing a wound: See attached pictures of wounds and describe one of them in detail in a progress note. 7/8/2020 - Administrator and DON will ensure skin assessments are completed weekly and accurately. They will also ensure all doctor orders for wounds are followed as ordered. Immediate Jeopardy (IJ) was removed on 7/10/2020 at 12:25 p.m. The facility remained out of compliance at a potential for actual harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 interviews and record review; it was determined the facility failed to ensure that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, and readily accessible for 1 of 5 residents reviewed for clinical records (Resident #1). Resident #1's clinical record failed to document how her left aka surgical incision appeared on admission or during her stay at the facility. There was no documentation found which contained what the surgical incision looked like, how many staples/sutures were there if there was any drainage. The facility's failure to ensure that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, and readily accessible place all residents requiring nursing care at risk for incorrect or omitted treatment, duplicated treatments, poor wound healing, worsening of wounds and pressure sores, infection,[MEDICAL CONDITION], and death. The evidence is as follows: Record review of Resident #1's clinical record revealed she admitted to the facility on [DATE], was [AGE] years old with the following Diagnoses: [REDACTED]. -A Medicare 5-day/Admission MDS resident assessment, dated 6/3/2020, documented the resident scored 13 of 15 on a mini-mental exam, required extensive assistance by one staff for locomotion in her room, requires limited assistance by one staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing, limited range of motion of one lower extremity, uses a wheelchair, occasionally incontinent of bladder, 62 inches tall and 159 pounds, surgical wound and surgical wound care. - Physician order [REDACTED].#1 was not having any problems with her stump. LVN C stated Resident #1's stump was draining in the middle but there was no odor or redness and it was not hot to touch. LVN C stated Resident #1 showered the night before she went to the doctor. LVN C stated Resident #1's stump looked good when she dressed it the night before she went to the doctor and she was not running a fever and her stump did not smell. LVN C stated she had taken care of Resident #1 for the three days before she went to the doctor. LVN C stated the day before Resident #1 went to the doctor, PT had informed her that Resident #1 had taken off her dressing while he was working with her. LVN C stated she had Resident #1 showered and she redressed her stump the night before her doctor's appointment and he stump did not have any signs of infection at that time. During an interview on 6/19/2020 at 3:00 p.m., the NP for Resident #1's physician stated she had discharged Resident #1 from the hospital today but she did not know what her stump looked like when she arrived at the doctor's office. NP stated she had only seen Resident #1 once and she did have some drainage from her wound but advised to contact the doctor after the weekend to get a better picture of how Resident #1's stump looked when she arrived at the doctor's office. During an interview on 6/19/2020 at 3:30 p.m., the PT stated he had been working with Resident #1 for a while and she was good at participating. PT stated he was supposed to do a home assessment for Resident #1 after her doctor's appointment but she ended up going to the hospital. PT stated the day before Resident #1 went to her doctor, her dressing was not staying on very well so they were

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) talking about doing her home assessment and all that would include. PT stated during this conversation with Resident #1, she kept messing with her dressing and finally pulled the dressing off. PT stated when he saw Resident #1's surgical incision, it just did not look good at all to him at all. PT stated Resident #1's surgical incision looked like it was possibly infected and had some necrotic tissue on the incision itself. PT stated he was not a nurse but Resident #1's incision did not look good. PT stated he told the nurse about Resident #1's incision and she was taken to the shower to clean her up and that was the last time he saw her. PT stated he was aware Resident #1 was going to see her doctor the next day so he was not too concerned. During an interview on 6/19/2020 at 4:00 p.m., the Administrator was informed that the Investigator would not be able to exit the facility until Resident #1's physician's office was contacted. AT this time, the Administrator was asked if there were any weekly skin assessments for Resident #1 and he found one assessment. Review of a Weekly Skin Assessment, dated 6/7/2020, documented Resident #1 had a surgical incision of left aka but it failed to have a description of the incision site, what it looked like and how many sutures or staples the incision had. This document was signed by the corporate nurse. Reviewed Daily Skilled Nursing Assessments, dated 5/29/202, 5/30/2020, 6/3/2020, 6/8/2020 and 6/11/2020, failed to document the condition of Resident #1's surgical incision or a description of the incision or how many staples/stiches were in place. Review of an Admission/Readmission Assessment, dated 6/2/2020, documented under Skin Integrity that Resident #1's skin was normal, warm and dry, and had the following: a. a bruise but did not note location or measurements b. skin tears but did not note location or measurements c. an abrasion but did not note location or measurements d. laceration but did not note location or measurements e. surgical incision but did not note location or measurements f. rash but did not note the location g. mositure associated skin damage but did not note location or measurements h. checked yes that resident had a pressure, venous, arterial, or diabetic ulcer. This document was signed by the corporate nurse NOTE: A Nursing Progress Note by the corporate nurse, dated 7/8/2020, documented the following: Late entry: on admission assessment, everything under skin was checked yes, the only thing that she (Resident #1) had was surgical incision. Doctor's records for Resident #1 Review of a fax received from Resident #1's orthopedic surgeon on 6/23/2020, documented the following findings: Patient presents today, 6/11/2020, post op of left aka. Patient states she is in pain today. 8/10. Has some gross drainage but denies nausea, vomiting, fevers or chills. Physical exam of left AKA stump - dehiscence with necrosis about the lateral edge. Will admit to the hospital and start on [MEDICATION NAME] antibiotics plan and take patient for surgical irrigation debridement - likely wound VAC placement. Surgery date 6/12/2020: preoperative Diagnosis: [REDACTED]. Procedure performed: left above-knee amputation, incision and drainage, 15 x 6 cm, excisional (remove) skin, subcutaneous tissue, bone and muscle. Cultures taken. Wound VAC placement. Surgery dated 6/16/2020: preoperative Diagnoses: [REDACTED]. Cultures taken. Secondary wound closure.