STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676309	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYWOOD CROSSING REHABILITATION & HEALTHCARE CENTE	5020 SPACE CENTER BLVD PASADENA, TX 77505

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 0573 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow residents/legal representative to obtain copies of the resident's medical records within 2 working days upon verbal or written request to the facility and at a reasonable cost-based fee for 1 of 8 residents (CR #1) reviewed for resident rights in that; The facility failed to charge CR #'1s RP a reasonable cost-based fee for copies of her medical records. The facility failed to ensure the RP received the copies of the requested medical records in a timely manner. These failures could affect residents who request copies of clinical records and placed them at risk of resident rights violations. Findings include: Record review of CR #1's face sheet revealed, a [AGE] year-old-female originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Telephone interview on 8/06/20 at 1:16pm with the Staff Ombudsman, she stated CR #1's RP informed her the facility charged her $742.00 for copies of her family member's medical records. She stated she called the facility and discussed the customary rates of charges for copies of records and sent the facility the federal regulations explaining the customary amount allowed to charge for record request. She said she informed the facility she contacted Office Depot who stated they would charge a maximum of $150.00 to copy 1000 pages. She further stated Office Depot charges $.15 cents per page and the fee decreased with more pages copied. She stated the RP paid the fee, but felt it was too much. She stated the RP explained to her the facility offered to refund her the money, but she declined because she needed the residents' medical records. Telephone interview on 8/06/20 at 1:42pm with the RP, she said she paid over $700.00 for her family member's medical records stating there were over 1,000 pages copied. She further stated Office Depot would have charged her $117.00 for copies of the same record. She stated she paid the fee because she needed to review the medical records. Telephone interview on 8/07/20 at 8:54am with Office Depot printing department, when asked how much it would cost to make black and white copies of 1068 pages, the representative stated, $138.84 before taxes. When asked if there was a different price for labor, she stated if an Office Depot employee makes the copies, the cost would be $0.19 cents per page and if the customer copies the documents it would cost $0.12 cents per page. Record review of the facility's Grievance log dated 08/03/20 revealed, a grievance filed by the Staff Ombudsman for CR #1 which read in part, Grievance /Complaint: Medical Records production fees. Assigned To: Admin; Resolution Informed of facility practice and charges and facility efforts to assist with viewing the records to lower cost or select the desired records. This was declined. Completed: Yes Record review of the facility's Resident/Grievance complaint form dated 8/03/20 read in part, RP called and asked for her (family member's) records. I explain the process to her also letting her know that she could view that anytime, but because of the pandemic, she would have to schedule a date and time to view them outside in front of the building with mask and gloves. She asked me if I talked to the Staff Ombudsman and I told her yes, but I can't discuss anything with her because of HIPAA. She proceeded to ask me if we talked about her (family member) and I explained that should call the Staff Ombudsman herself. RP asked me if I knew who the Staff Ombudsman was, and I told her yes. Record review of the Staff Ombudsman e-mail dated 7/31/20, read in part, I spoke to both of you (Health Information Coordinator and Administrator) about the medical records total price for CR #1. Attached is the TAC 40. When you open the document, search community standard. Community standard rate is compared to the nearest printing companies. I called the nearest Office Depot to the facility. Charges $0.15 a page and decrease in cost with additional pages, no base fee. 1069 pages x $0.15 is $160.20 . Record review of the Health information coordinator notes dated 8/3/20 read in part, Spoke to the Staff Ombudsman informed that the link did not indicate community standards. She said she called Kinkos and we charge more. Tried to explain that we charged per policy not by copy store pricing. Record review of the facility's Release of Health Information and Charges dated 7/17/20 revealed, the RP requested the release of CR #1's complete medical on 7/17/20, number of pages copied, 1282. Charges read in part, Charge: $45.88 for the first 10 pages, $77.00-$1.54 for each page of 11th through 60th of provided copies; $258.40- $.76 for each page of 61st through 400th of provided copies; $361.62 $.41 for each remaining pages of provided copies; total charge of $742.90. The RP chose to pay the $742.90 for the complete medical record. Further record review of the facility's Release of Health Information and Charges dated 7/17/20 revealed, the RP requested the release of CR #1's complete medical records, this form detailed the cost for only PCC records which read in part, Number of pages 1078; Charge: $45.88 for the first 10 pages; $77.00-$1.54 for each page of 11th through 60th of provided copies; $258.40-$.76 for each page of 61st through 400th of provided copies; $277.98-$.41 for each remaining pages of provided copies; Total charges: $659.26. Interview on 8/07/20 at 10:59am with the Health Information Coordinator, when asked if she completed the Release of Health Information and Charges form for CR #1's, she stated the form was e-mailed to the complainant, last week and the RP paid for the records that Friday. She stated the RP said her fax was not working, so the RP provided her the information and she completed the form. She stated confirmation was done prior to completing the form. She said two forms were processed, one in which the RP requested the complete medical record and the second form was requesting only the PCC record. She stated the RP ended up requesting the entire medical record, stating she wanted everything copied. She stated the total fee charged for the complete medical record was $742.90 which included a total of 1282 pages. Further interview on 8/07/20 at 10:59am with the Health Information Coordinator, when asked how the facility comes up with the fees/charges for copies of medical records, she stated the form she provided with the listed fees is what they have used for the five years she has been working at the facility. When asked if the fees for record requests are in the admission packet so families are aware of the cost, she said she was not sure. She stated when a resident or RP request records, she tells them at that time how much it will cost. She said she generates an invoice and will then ask the RP if they want to proceed. If they want to proceed they must pay first before the record request will be processed. She stated once payment is received, she has 30 days to get the records to them. Further interview on 8/07/20 at 10:59am with the Health Information Coordinator, she stated basically the fees were different for everyone because it is based off the number of pages requested to be copied. When asked if CR #1's RP picked up the records or if they were mailed, she said the RP had not picked up the records because they were still being processed by PCC. She stated when the RP picks up the records, she would make a copy of her driver's license for verification and the RP or carrier will have to sign the form showing the records were picked up. Interview on 8/07/20 at 11:19am with the Admissions Coordinator, when asked if the Release of Health Information and Charges form is part of the Admission packet, she stated no, it was usually given to the family/RP upon request. When asked if the fees to copy records is discussed during the admissions process, she stated again no, the Health Information Coordinator will discuss the fees at the time records are requested. Interview on 08/07/20 at 2:24pm with the Administrator, she stated CR #1's RP was charged a reasonable and customary cost for the copies of CR #1's medical records. She stated the fees were based from a letter Texas Health and Human Services provided detailing the maximum fees allowed for copies of records. She further stated the facility charges slightly under what the maximum fees allowed in the

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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BAYWOOD CROSSING REHABILITATION & HEALTHCARE CENTE	**5020 SPACE CENTER BLVD PASADENA, TX 77505**

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F 0573 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) letter. Record review of the Texas Health and Human Services Maximum Fees Allowed for Providing Health Care Information Effective September 1, 2019 read in part, .This information is provided only as a courtesy to licensed hospitals. Hospitals are responsible for verifying fees for health care information are charged in accordance with Health and Safety Code, Chapters 241, 311, and 324 . The letter the Administrator provided to the surveyor was for licensed hospitals and did not indicate it applied to nursing facilities. Record review of the facility's Release of Information revised March 2014 read in part, .Policy Interpretation and Implementation .8. The resident may initiate a request to release such information contained in his/her records and charts to anyone he/she wishes. Such requests will be honored only upon the receipt of a written, signed, and dated request from the resident or representative (sponsor). 9. A resident may have access to his or her records within__ hours (excluding weekends or (48) hour (excluding weekends and holidays) advance notice of such request. A fee may be charged for copying services . The policy did not detail the fees charged for copies of records.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals to meet the needs of each resident for 1 of 8 residents (Resident #5) observed for medication administration in that; LVN #3 failed to administer Resident #5's [DEVICE] water flush and medications within an hour of their prescribed time. This failure could affect residents that received [DEVICE] medications and place them at risk of not receiving the intended therapeutic benefits of their medications and a decline in health. Findings include: Record review of Resident #5's face sheet revealed, an [AGE] year-old-male admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #5's Admission MDS dated [DATE] revealed, a BIMS score of 4 indicating severe cognitive impairment. Record review of Resident #5's Care plan target date 9/22/20 read in part, Focus: The resident has impaired cognitive function, memory loss and/or impaired thought processes r/t Dementia .Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness . Further record review of Resident #5's Care plan revised 6/19/20 read in part, Focus: The resident has dehydration/potential fluid deficit/potential for fluctuation in fluid volume r/t tube feeding tube, flushes .Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness . Record review of Resident #5's physician orders [REDACTED]. Tablet Give 1 tablet via PE[DEVICE] one time a day for Allergy symptoms; [MEDICATION NAME] Tablet 1000 UNIT Give 2 tablet via PE[DEVICE] one time a day for Supplement; [MEDICATION NAME] Respimat Aerosol Solution 20-100 MCG/ACT ([MEDICATION NAME]-[MEDICATION NAME]) 1 inhalation inhale orally four times a day for Shortness of Breath; [MEDICATION NAME] Packet 40 MG (NAME]) Give 1 packet via PE[DEVICE] two times a day for worsening [MEDICAL CONDITION] for 60 days; [MEDICATION NAME] Tablet 5 MG (linaGLIPtin) Give 1 tablet via [DEVICE] one time a day for Blood Sugar Control; Vitamin B-1 Tablet 100 MG ([MEDICATION NAME] HCL) Give 1 tablet via PE[DEVICE] one time a day for Supplement. Record review of Resident #5's August MAR indicated [REDACTED]. Observation on 8/06/20 at 10:52am of Resident #5 revealed, the resident asleep, lying on his right side with music playing. The HOB was elevated approximately 30 degrees, Glucerna 1.5 TF infusing at 75cc/hr via PEG tube. TF bag dated 8/6/20, syringe bag dated 8/6/20. Observation and interview on 8/06/20 at 10:58am with LVN #3, she was observed administering medications to the resident in room [ROOM NUMBER]. The surveyor asked the LVN if she was going to administer medications to Resident #5, she stated yes after she finished passing meds to the resident in Rm 401 and Rm 405. The surveyor waited from 10:58am to 11:48am for the nurse to pass medications to Resident #5. When again asked if she was going to administer Resident #5's medications, she stated she had to give one more medication down the hall. She was observed passing medications to a resident down the hall. She then stated she was going to have to eat before administering his medications further stating, her head was swimming and she had to eat. She stated after she ate, she would pass medications to Resident #5. The LVN was observed pushing her medication cart to the nurses' station and informed LVN #1 she was going to eat lunch. Interview on 8/06/20 at 12:11pm with LVN #1, when asked if Resident #5 had morning medications that needed administered, she stated the ADON talked to LVN #3 and LVN #3 informed the ADON she did not give anything. LVN #1 stated at that time the ADON called the resident's NP to inform her the medications were past due and ask if they could be administered late. LVN #1 stated the residents' medications were late and should have been administered by LVN #3. Record review of nursing health status note dated 8/06/20 read in part, Late Entry for 8/6/2020 at 12:05p.m. spoke with FNP for res. Informed her that res meds were not given at the prescribed time, New order was received to give meds at this time. Res. Resting quietly in room. No s/s of distress noted. No facial grimacing noted at this time. Interview on 8/06/20 at 12:20pm with the ADON, when asked if Resident #5 had morning medications due, she stated yes. When asked why LVN #3 skipped the resident's room to administer medications in room [ROOM NUMBER], and did not administer the resident's medications before going on lunch break, and failed to inform her, the NP or MD the medications were not administer on time, the ADON stated she called the NP and the NP ok'd to give the medications late. Interview and observation on 8/06/20 of med pass at 12:38pm with Resident #5 and LVN #1, she stated she would be administering the residents' medications stating the NP gave orders to administer the medications late. Observed the LVN hold the residents TF, HOB was elevated, she explained to the resident she was going to administer his medications. [DEVICE] placement was assessed, residuals checked, < 5 cc residuals withdrawn. All tablets were crushed and mixed with 10cc of H2O. Observed he LVN administer 450 H2O flush, Tylenol 325 mg 2 tablets, [MEDICATION NAME] powder 1 packet, Acidophilus 1 capsule, [MEDICATION NAME] 10mg 1 tablet, [MEDICATION NAME] 5 mg 1 tablet, Vitamin D 1000 IU 2 tablets, Vitamin B-1 1 tablet, [MEDICATION NAME] 1 packet. All medications were administered via [DEVICE] with the appropriate H2O flush before and after. The LVN administered the [MEDICATION NAME] inhaler, 1 inhalation after all [DEVICE] medications were administered. Interview on 8/06/20 at 12:54pm with LVN #3, when asked why she did not administered Resident #5's medications and instead went to the room next to his to administer medications and then administered medications to a resident down the hall, she stated she wanted the midline nurse to finish what she was doing, stating she liked to do all of his things at once. When informed there was not a nurse in the room at the time she was observed passing medications, she again stated she liked to do all of his things at once. When asked why she did not administer the residents' medications before going to lunch, and why she did not inform the ADON the medications were going to be administer late, she could not state why. When asked what the facility's policy was regarding administering medications in a timely manner, and notifying the DON, MD/NP of late medication administration, she stated she did not know the policy and would have to look it up, further stating she can ask. Interview on 8/06/20 at 1:00pm with the ADON, when informed LVN #3 stated she did not know the facility's policy on timely medication administration, but said she knew about medication administration times. Record review of the facility's Administering Medications policy revised December 2012 read in part, Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation .3. Medications must be administered in accordance with orders, including any required time frame. 4. Medications must be administered within (1) hour of their prescribed time, unless otherwise specified (for example, before bed and after meal orders) .7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .

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 interview, and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards of practice for 6 of 8 residents (CR #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) reviewed for medical records in that; CR #1 and Residents #2, #3, #4, #5, and #6's July TAR had multiple days of missing documentation for wound care. The facility failed to complete weekly skin assessments on Residents #2, #3, #4, #5, #6. The facility failed to complete the Weekly Pressure Ulcer and Non-Pressure Ulcer reports for two weeks. These failures could affect all residents and placed them at risk of having incomplete and inaccurate records which could impact their treatment and health. Findings include: CR #1 Record review of CR #1's face sheet revealed, a [AGE] year-old-female originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of CR #1's Care plan revised 5/28/20 read in part, Focus: alteration in skin integrity related to pressure ulcer/pressure injury secondary to: Impaired mobility, Incontinency .Interventions: Keep skin clean and dry. Provide incontinent care quickly as possible following episodes of voiding or bowel movement. Assist/Encourage/Remind resident to turn and reposition every two hours to relieve pressure. Inform physician, family, dietician, and director of nursing of any new skin breakdown. The care plan did not address wound assessment and/or documentation of wound care or progression. Record review of CR #1's physician orders [REDACTED].? Document Y-yes or N= no. Drainage? Document S= saturated M= moist D= dry one time a day To Aid in Wound Healing. General Appearance? Document R=red; Y=yellow; B=black; G=green; W=white; P=pink; T=tan; PU=purp; BR-brown; GR=gray; O=other. Surrounding Skin? Document M=macerated; R= reddened; F=firm; N=normal. Further record review of CR #1's physician orders [REDACTED].? Document Y-yes or N= no. Drainage? Document S= saturated M= moist D= dry one time a day To Aid in Wound Healing General Appearance? Document R=red; Y=yellow; B=black; G=green; W=white; P=pink; T=tan; PU=purp; BR-brown; GR=gray; O=other AND surrounding Skin? Document M=macerated; R= reddened; F=firm; N=normal. Further record review of CR #1's physician orders [REDACTED].? Document Y-yes or N= no. Drainage? Document S= saturated M= moist D= dry one time a day To Aid in Wound Healing General Appearance? Document R=red; Y=yellow; B=black; G=green; W=white; P=pink; T=tan; PU=purp; BR-brown; GR=gray; O=other. AND surrounding Skin? Document M=macerated; R= reddened; F=firm; N=normal. Record review of CR #'s physician orders [REDACTED]. One time a day. Record review of CR #1's physician orders [REDACTED]. One time a day. Left medial distal foot wound; clean with NS; Santyl ointment, calcium alginate and dry dressing QD. One time a day. Record review of CR #1's physician orders [REDACTED]. One time a day. Clean left medial distal foot wound with NS; calcium alginate, abdominal pad, kerlix QD. One time a day. Record review of CR #1's July TAR revealed, on 7/11/20 there was no documentation showing wound care was completed to the residents left medial distal foot wound. Further record review of CR #1's July TAR revealed, on 7/18/20 and 7/19/20 there was no documentation showing wound care was completed on the laceration under the residents [DEVICE]. Further record review

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F 0842

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)

of CR #1's July TAR revealed, on 7/11/20, 7/18/20, and 7/19/20 there was no documentation showing wound care was completed to the resident's right heel wound, and right medial distal foot wound. Further record review of CR#1's July TAR revealed, on 7/11, 7/18, and 7/19 there was no documentation showing observations with each dressing change of the left medial distal foot wound, right medial distal foot wound, and right medial heel wound was completed during wound care. Resident #2 Record review of Resident #2's face sheet revealed, an [AGE] year-old-female originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Quarterly MDS dated [DATE] revealed, documentation in the Staff Assessment for Mental Status showing short and long-term memory problems and Severely Impaired Cognitive Skills for Daily Decision Making. Further record review of Resident #2's physician orders [REDACTED].? Document & = yes N = no. AND Drainage? Document: S= saturated M= moist D= dry one time a day for TO Aid in Wound Healing. General Appearance? Document: R= red; Y= yellow; B= black; G=green; W=white; P=pink; T=tan; PU=purp; BR=brown; GR=gray; O=Other. AND Surrounding Skin?
Document M= macerated; R= reddened; F=firm; N=normal. Record review of Resident #2's physician orders [REDACTED]. One time
a day. Record review of Resident #2's Care plan revised on 6/4/20 read in part, Focus: 6/2/2020: sacral wound-5.5x4.0x0.4; no improvement- treatment changed .Interventions: Monitor/document location, size and treatment of [REDACTED]. to MD. The interventions did not address the sacral PU. Record review of Resident #2's July TAR revealed, on 7/2/20 and 7/12/20, there was no documentation showing wound care was completed on the residents' stage IV sacral wound. Further record review of Resident #2's July TAR revealed, on 7/2/20 and 7/12/20, there was no documentation showing observation with each dressing change of the sacral wound was completed during wound care. Record review of Resident #2's Weekly Skin Assessments revealed, the skin assessment was not completed for the week of 7/30/20. When the surveyor requested the weekly skin assessment for week of 7/30/20, it was showing in progress in the EHR. Resident #3 Record review of Resident #3's face sheet revealed, a [AGE] year-old-female admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's Quarterly MDS dated [DATE] revealed, A BIMS score of 3 indicating severe cognitive impairment. Record review of Resident #3's Care plan revised 7/29/20 read in part, Focus: Impaired skin integrity related to impaired mobility, impaired cognition, self-care deficit, co-morbidity/medication evidenced by right distal lateral foot(STAGE III) pressure injury, right distal medial foot (Unstageable) pressure injury and Sacral (stage III) pressure injury .Interventions .Inform physician, family, dietician, and director of nursing of any new skin breakdown. There was no documentation in the care plan addressing wound assessment and documentation. Record review of Resident #3's physician orders [REDACTED].? Document: Y=yes or N= no. AND Drainage? Document: S= saturated M= moist D= dry one time a day for TO Aid in Wound Healing. General Appearance? Document: R-red; Y- yellow; B=black; G=green; W=white; P=pink; T=tan; PU=purp; BR=brown; GR=gray; O=other. AND
Surrounding Skin? Document M=macerated; R= reddened; F= firm; N= normal. Further record review of Resident #3's physician orders [REDACTED]. One time a day. Further record review of Resident #3's physician orders [REDACTED]. Further record review of Resident #3's physician orders [REDACTED].? Document: Y=yes or N= no. AND Drainage? Document: S= saturated M= moist D= dry one time a day for to Aid in Wound Healing. General Appearance? Document: R-red; Y- yellow; B=black; G=green; W=white; P=pink; T=tan; PU=purp; BR=brown; GR=gray; O=other. AND Surrounding Skin? Document M=macerated; R= reddened; F=
firm; N= normal. Record review of Resident #3's July TAR revealed, on 7/12/20 and 7/26/20 missing documentation showing wound care was completed on the residents right lateral distal foot wound. Further record review of Resident #3's July TAR revealed, on 7/12 and 7/26 missing documentation showing wound care observation was completed on the right lateral foot wound with each dressing change. Further record review of Resident #3's July TAR revealed, on 7/26/20 missing documentation showing wound care was completed on the residents right medial distal foot wound. Further record review of Resident #3's July TAR revealed, on 7/26/20 missing documentation showing wound care observation was completed on the right medial distal foot wound with each dressing change. Record review of Resident #3's Weekly Skin Assessment revealed, a skin assessment was not completed for the week of 7/20/20. Resident #4 Record review of Resident #4's face sheet revealed, an [AGE] year-old-female admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's Admission MDS dated [DATE]
revealed, a BIMS score of 2 indicating severe cognitive impairment. Record review of Resident #4's Care plan revised 7/02/20 read in part, Focus: Resident has the potential for alteration in skin integrity related to pressure ulcer/pressure injury secondary to: Impaired mobility, Incontinency .Interventions: .Inspect skin from head to toe no less than one time per week and document/measure all abnormal findings . Record review of Resident #4's physician orders [REDACTED]. Heel protector to left heel to be worn, at all times-except for bathing. One time a day. Further record review of Resident #4's physician orders [REDACTED].? Document Y= yes or N= no. AND Drainage? Document: S= saturated M= moist D= dry one time a day for to Aid in Wound Healing. General Appearance? Document: R=red; Y= Yellow; B=black; G=green; W=white; P=pink; T=tan; PU=purp; BR=brown; GR=gray; O=other. AND Surrounding Skin? Document M= macerated; R=reddened; F=firm; N=normal. Record
review of Resident #4's July TAR revealed, 7/2/20, 7/11/20, and 7/12/20 missing documentation showing wound care was completed on the residents left heel wound. Further record review of Resident #4's TAR revealed, on 7/2/20, 7/11/20, and 7/12/20 missing documentation showing wound observation of the left heel was completed during each dressing change. Record review of Resident #4's Weekly Skin Assessment revealed, weekly skin assessments were not completed for the weeks of 7/13/20 and 7/27/20. Resident #5 Record review of Resident #5's face sheet revealed, an [AGE] year-old-male admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #5's Admission MDS dated [DATE] revealed, a BIMS score of 4
indicating severe cognitive impairment. Further record review of Resident #5's physician orders [REDACTED].? Document: Y= yes or N= no. AND Drainage? Document: S= saturated M= moist D= dry one time a day for To Aid in Wound Healing. General Appearance? Document: R=red; Y= yellow; B=black; G=green; W=white; P=pink; T=tan; PU=purp; BR=brown; GR=gray; O=other. AND
Surrounding Skin? Document: M=macerated; R=reddened; F=firm; N= normal. Record review of Resident #5's Care plan revised 6/19/20 read in part, Focus: The resident has stage IV pressure ulcer/pressure injury to sacrum with an increased potential for pressure ulcer/pressure injury development and/or potential for worsening/additional pressure ulcer/pressure injury r/t Hx of pressure ulcers or pressure injury, Immobility, Incontinent of Bladder, Incontinent of Bowel .Interventions:
Evaluate/record/monitor wound healing with each dressing change. Measure length, width and depth (where possible) at least one time per week. Evaluate and document stated of wound perimeter, wound bed and health progress . Record review of Resident #5's physician orders [REDACTED]. One time a day. Record review of Resident #5's July TAR revealed, on 7/2/20, 7/11/20, 7/12/20 and 7/18/20 missing documentation showing wound care was completed on the residents sacral wound. Further record review of Resident #5's July TAR revealed, on 7/2/20 7/11/20, 7/12/20, and 7/18/20 missing documentation showing wound observation of the sacral wound was completed during each dressing change. Record review of Resident #5's Weekly Skin Assessment revealed, a weekly skin assessment was not completed for the week of 7/13. Resident #6 Record review of Resident #6's face sheet revealed, a [AGE] year-old-male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's Quarterly MDS dated [DATE] revealed, a BIMS score of 13 indicating intact cognition. Record review of Resident #6's Care plan revised 5/06/20 read in part, Focus: .Resident as DM ulcer to right lateral foot .Interventions: .Inspect skin from head to toe no less than one time per week and document/measure all abnormal findings . Record review of Resident #6's physician orders [REDACTED]. Cover site with [MEDICATION NAME] gauze, abdominal pad. Wrap with kerlix and ACE wrap QD. One time a day. Record review of Resident #6's physician orders [REDACTED]. One time a day. Record review of Resident #6's July TAR revealed, on 7/11/20 missing documentation showing wound care was completed on the residents right lateral foot skin graft. Further record review of Resident #6's July TAR revealed, on 7/26/20 missing documentation showing wound care was completed on residents right lateral foot ulcer. Record review of Resident #6's Weekly Skin Assessment revealed, a weekly skin assessment was not completed for the week of 7/13/20. Record review of the facility's Weekly Pressure Ulcer Log and Non-Pressure Ulcer Log revealed, the weekly logs were not completed for the weeks of 7/20/20 and 7/27/20. Interview on 8/07/20 at 10:31am with the Treatment Nurse, he said he started working at the facility as the treatment nurse the last week of July, stating 7/29/20. When asked when the previous treatment nurse left, he stated he thinks that previous week on Tuesday. When asked who was completing wound care, the weekly wound assessments, and weekly wound reports he stated the DON. Interview on 8/07/20 at 11:25am with the ADON, when informed multiple residents had missing weekly skin assessments and documentation on the TARs showing wound care was completed as ordered, she said she knows wound care was completed by the DON during the weekdays and LVN #1 completed wound care on the weekends until she got sick then the DON had to do the wound care. She said LVN #1 would do wound care on Sundays and LVN #2 would do wound care on Saturdays. She again stated the DON would do wound care if the LVNs could not could not. Further interview on 8/07/20 at 11:25am with the ADON, when asked where the weekly pressure ulcer and non-pressure ulcer reports were for the weeks of 7/20/20 and 7/27/20 she stated she was completing them then found out they weren't up to par, stating she has a folder and she thought she was putting them in the folder. She further stated the previous treatment nurse's last day was on 7/23/20, so the weekly PU reports weren't completed because she was out. Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676309	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYWOOD CROSSING REHABILITATION & HEALTHCARE CENTE	**5020 SPACE CENTER BLVD PASADENA, TX 77505**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) review of the facility's Charting and Documentation Policy revised July 2017 read in part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .Policy Interpretation and Implementation .2. The following information is to be documented in the resident medical: .c. Treatments or services performed .7. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual (s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family; physician or other staff, if indicated; and g. The signature and title of the individual documenting.