| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455528 | A. Building<br>B. Wing | 06/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Laredo West Nursing and Rehabilitation Center | 1200 Lane<br>Laredo, TX 78043 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47371<br><br>Based on observation, interview, and record review the facility failed to ensure residents who entered the facility without pressure ulcers did not develop pressure ulcers and a resident having pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown or pressure ulcers for one (R #2) of eight residents reviewed for pressure ulcers.<br><br>-The facility failed to assess and document a detailed description of R #2's pressure ulcers upon admission other than he was admitted with a friction tear to right buttock and deep tissue pressure injury to bilateral heels.<br><br>-The Admitting RN failed to consult with R #2's physician upon admission when he saw R #2's friction tear to right buttock and deep tissue pressure injury to bilateral heels leaving the resident to go without preventative wound care for 7 days after admitted [DATE].<br><br>These failures could place residents with pressure ulcers as well as other residents receiving preventive skin care at risk for developing new pressure ulcers or a deterioration in existing pressure ulcers.<br><br>The findings included:<br><br>Review of the Face Sheet dated 06/23/2023 revealed R #2 was a [AGE] year-old male, who was initially admitted to the facility on [DATE] and readmitted on [DATE] and 06/09/2023. His diagnoses included Type Two Diabetes; Acute kidney failure; Pneumonia; Severe sepsis with septic shock; Hypertension; Atrial Fibrillation; and pressure ulcer of sacral region (the portion of your spine between your lower back and tailbone).<br><br>Review of R #2's Minimum Data Set (MDS) assessment dated [DATE], reflected it did not code R#2 with pressure ulcers.<br><br>Review of R #2's Start Up Orders dated 03/09/2023 revealed no wound care orders.<br><br>(continued on next page) |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 455528 | A. Building<br>B. Wing | 06/23/2023 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Admission Data Summary/Progress Note dated 03/09/2023 revealed R #2's ADLs function prior to admission was that he required partial/moderate assistance for mobility and transfer; required some supervision or touching assistance with eating; was incontinent of bowel and bladder. R #2 had an unstable gait. He could usually understand others and make himself understood. R #2 was not in pain. R #2 was not at risk for wandering. R #2 had excoriations to buttock, friction tear to right buttock, and deep tissue pressure injury to bilateral heels documented.There was no other documentation of the detailed description of the ulcers. There were no pressure ulcers documented on the Initial Nursing Evaluation/Admissions Assessment .<br><br>Review of R #2's Physician Orders dated 03/16/2023 documented Wound Care: Unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) in the wound bed) Pressure Ulcer: Left Heel/Right Heel: Cleanse with NS [normal saline], pat dry, apply Santyl ointment to wound bed, cover with absorbent dressing, wrap with gauze bandage roll, and secure with Medfix QOD [every other day] and PRN [as needed] if soiled/loose every dayshift. Heel floater (suspends the heel over an air cavity. This creates a barrier between skin and any surfaces that may cause pressure or friction, reducing the risk of damage to the skin) at all times while in bed every shift. Monitor Stage II [Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister] pressure injury to left buttock and document (+) if there are no observed abnormalities or changes to the dressing, skin, or pain associated with the wound. Document (-) if abnormalities or drainage to the dressing, skin, or pain associated with the wound are present or observed every shift.<br><br>Review of R #2's Care Plan dated 03/16/2023 revealed R#2 had pressure ulcers or potential for pressure ulcer development r/t mobility limitations, incontinence, Stage IV Left Heel, Stage IV Right Heel, and Stage IV Sacrum. R#2's goal was the resident's pressure ulcers will show signs of healing and remain free from infection by/through review date. Interventions documented for R#2 were: The resident requires the bed as flat as possible to reduce shear (break off or cause to break off). Administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the MD. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Monitor dressings to ensure it is intact and adhering. Report loose dressing to treatment nurse. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. The resident needs to turn/reposition at least every 2 hours, more often as needed or requested. Wound Vac (negative-pressure wound therapy, also known as a vacuum assisted closure, is a therapeutic technique using a suction pump, tubing, and a dressing to remove excess exudate and promote healing in acute or chronic wounds) as ordered.<br><br>Review of R #2's Weekly Pressure Ulcer Skin Evaluation reflected:<br><br>- 03/09/2023: There was no detailed description of the ulcers documented, making it difficult to know the wounds appearance, amount, and type of drainage<br><br>- 03/16/2023: documented by wound care LVN revealed:<br><br>(continued on next page) |

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| | 455528 | A. Building<br>B. Wing | 06/23/2023 |

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| Laredo West Nursing and Rehabilitation Center | 1200 Lane<br>Laredo, TX 78043 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1. Left Heel: Unstageable: 6.9cm (length) X 5.6cm (width), exudate serosanguineous (thin, watery, pale red/pink) drainage.<br><br>2. Right Heel: Unstageable: 5.6cm (length) X 5.3cm (width) exudate serosanguineous drainage.<br><br>3. Sacrum unstageable: 3.5cm (length) X 1.4cm (width) no exudate documented.<br><br>-03/30/2023<br><br>1. 1.Left Heel: Unstageable : 6.2cm (length) X 4.8cm (width), no exudate documented.<br><br>2. 2.Right Heel: Unstageable: 5.8cm (length) X 5.0cm (width) no exudate documented.<br><br>3. 3.Sacrum Stage II : 6.3cm (length) X 6.2cm (width) no exudate serous documented.<br><br>Review of R #2's March 2023 Treatment Administration Record (TAR) revealed Wound Care: Unstageable Pressure Ulcer: Left Heel/Right Heel: Cleanse with NS [normal saline], pat dry, apply Santyl ointment to wound bed, cover with absorbent dressing, wrap with gauze bandage roll, and secure with Medfix QOD [every other day] and PRN [as needed] if soiled/loose every dayshift. Heel floater at all times while in bed every shift. Monitor Stage II [Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister] pressure injury to left buttock and document (+) if there are no observed abnormalities or changes to the dressing, skin, or pain associated with the wound. Document (-) if abnormalities or drainage to the dressing, skin, or pain associated with the wound are present or observed every shift - Start 03/16/2023. The TAR documented that this treatment was done daily beginning on 03/16/2023 and ending on 03/20/2023.<br><br>Review of R #2's Progress/Nurse's Notes dated 03/09/2023 - 03/16/2023 revealed no detailed description of R #2's pressure ulcers. On R#2's Admission's Progress Note, the RN documented, Skin: Skin changes since last evaluation: No; Does resident have treatable wounds: No.<br><br>Review of Progress/Nurse's Note dated 03/16/2023, completed by R #2's Wound Care Nurse, revealed R#2 was seen at bedside for skin assessment status post reports of seeping gauzes by therapy team to resident's feet; wound care nurse was not made aware of findings upon admission and no orders were placed in Point Click Care (electronic health record) for wounds. during assessment, it was noted that resident had large, oversized hospital grip socks with drenched gauzes underneath. resident's dressings were dated 3/7/2023. resident presents with unstageable pressure injuries bilateral heels. resident was also noted with unstageable pressure injury to sacrum and stage II to left buttock. FNP in facility and assessed areas and gave orders. Resident is to be set-up with wound care clinic per FNP<br><br>Unable to observe R#2 due to the expirational discharge of R#2 on 06/13/2023.<br><br>(continued on next page) |

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| | 455528 | A. Building<br>B. Wing | 06/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Laredo West Nursing and Rehabilitation Center | 1200 Lane<br>Laredo, TX 78043 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the RN A on 06/23/2023 at 10:05AM, she stated she was recently hired within the past two months, and was not employed between 03/09/2023-03/16/2023. RN A stated upon a resident's admission, the admitting nurse will notify the Physician of any skin abnormalities shortly after the admission process is completed. RN A stated the expectation is to make sure proactive and precautionary measures are initiated as quickly as possible to ensure the safety of all residents. The admitting nurse will then notify the Wound Care Nurse via verbal notification as well as through initial assessments, progress notes, or computer orders. RN A stated it was unacceptable for R#2 to go without any preventative wound care for seven days (03/09/2023-03/16/2023). RN A stated if wounds and pressure ulcers are not proactively acted upon, wounds/pressure ulcers can enlarge, open, or become infected (which upon record review for R#2 bilateral heels skin opened). RN A stated infections could potentially compromise a resident's health and safety. The RN A theorized R#2's admitting nurse did not follow the facility's policy and procedure regarding a head-to-toe body evaluation upon admission. The RN A stated she does not recollect when she was last in-serviced about policy and procedures regarding admission skin integrity management assessments.<br><br>During an interview with the Administrator on 06/23/2023 at 11:15 a.m. revealed he was on leave during the month of March 2023, and an interim Administrator was in charge. The Administrator stated the expectation of the facility was for the discovering nurse to follow through and call the physician to notify of any skin abnormalities. The Administrator stated the previous wound care nurse was not efficient nor effective and should have been proactive to check skin assessments on all admissions. The Administrator stated he terminated the previous Wound Care Nurse shortly after the incident with R#2. The Administrator stated it was unacceptable for the admitting nurse of R#2 to not notify R#2's Physician, thus jeopardizing the resident's skin integrity for seven days which could have led to the injuries to open or become infected (which upon record review for R#2 bilateral heels skin opened). The Administrator stated the admitting nurse of R#2 in question, is no longer employed at the facility. The Administrator stated it was the facility's expectation that all nurses follow the policy and procedures regarding admissions. The Administrator stated he has just employed a new DON within the past 2 months who has begun reeducating all nursing staff on admission requirements in conjunction with policy and procedures and was confident of the changes the DON has made.<br><br>Record review of the facility's Skin Integrity Management System, undated, stated: A head-to-toe body evaluation will be completed on every resident upon admission or readmission on the Initial Nursing Evaluation. Weekly thereafter the evaluations will be documented on the weekly Skin Evaluation UDA . If skin is compromised, proceed to the Weekly Wound Progress UDA.<br><br>A. Identified skin areas will be documented on the Weekly Pressure or Non-Pressure UDA. Wound progress is to be documented each week with measurements and wound description.<br><br>1. Treatment for an identified area is documented on the Treatment Administration Record (TAR)<br><br>a. Dressings are to be dated and initialed upon completion<br><br>2. Progress of the identified area will be documented on the Weekly Pressure or Non-Pressure UDA at least every 7 days, or less if the wound shows a decline or is healed. The Physician is to be contacted after 14 days if the area has not shown improvement or immediately if it shows a decline. Documentation of the Physician notification is to be in the Progress Notes.<br><br>(continued on next page) |

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| | 455528 | A. Building<br>B. Wing | 06/23/2023 |

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| Laredo West Nursing and Rehabilitation Center | 1200 Lane<br>Laredo, TX 78043 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | According to the National Pressure Ulcer Advisory Panel website (http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/) searched on 07/03/2023 revealed:<br><br>Pressure Injury Prevention Points: Risk Assessment:<br><br>1. Consider bedfast and chairfast individuals to be at risk for development of pressure injury .<br><br>1.Inspect all of the skin upon admission as soon as possible (but within 8 hours).<br><br>2.Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema (discoloration of the skin that does not turn white when pressed).<br><br>3.Assess pressure points, such as the sacrum, coccyx (tailbone) , buttocks, heels, ischium (bottom of the pelvis) , trochanters (upper part of the thigh bone), elbows, and beneath medical devices . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038<br><br>Based on observation, interview, and record review the facility failed to establish and maintain an Infection Prevention and Control Program designed to help prevent the standard and transmission-based precautions to be followed to prevent the spread of infections or diseases for 1 resident, Resident #1 (#R1) of one resident observed for infection control.<br><br>The facility failed to perform hand hygiene between glove change while assisting R #1 with personal care<br><br>-perform sanitary cleaning during care for R #1.<br><br>These failures could have affected 1 resident at risk for improper care, infections, and illnesses.<br><br>Findings include:<br><br>Record review of R#1's clinical file revealed an [AGE] year-old male, with an original admitted [DATE]. Diagnosis included, Atrial Fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the atrial chambers of the heart), Hemiplegia (paralysis of one side of the body), Diabetes Insipidus (disorder that causes the body to make too much urine), Diabetes Mellitus (inability of the body to produce or respond to insulin and maintain proper levels of blood sugar in the blood), Peripheral Vascular Disease ( narrowing of arteries), Hypothyroidism (thyroid gland does not produce enough thyroid hormone), Altered Mental Status, Contractures of Muscles, Heart Failure, Pressure Ulcer to Right Heel (unstageable), and Cystitis with Hematuria (infection if the urinary bladder).<br><br>Resident #1's most recent MDS data dated 6/13/2023 identified a BIMS (Brief Interview of Mental Status,) score of 06 (Severly Impaired Cognition). R#1 requires extensive assistance on bed mobility, transfers, dressing, toilet use, and personal hygiene.<br><br>Observation of peri care (Perineal Care, breif change) on 6/23/23 at 9:39am. revealed CNA A and CNA B sanitized hands prior to putting on gloves. CNA B grabbed a trash bag and put it on Resident #1's bed to discard soiled items. CNA A gathered the rest of the supplies needed for peri care for R#1. CNA B held R#1 in a turned position (facing CNA B). CNA A removed R#1's brief, grabbed a wipe and wiped the resident from front to back repeatedly without using a new wipe or folding the wipe for a clean surface to be used. CNA A cleaned R#1 with a visibly soiled wipe multiple time. CNA A then took off soiled gloves and put on new gloves without sanitizing hands or washing hands, then proceeded to put on new pair of gloves. CNA A placed a new brief on R#1.<br><br>Interview with CNA A and CNA B at 10:15am on 6/23/2023. CNA B has been at the facility for [AGE] years and worked as a CNA at the facility for 9 years. CNA B stated, between glove changes, hands should be washed, or sanitized. Both CNA A and CNA B stated, they did not perform hand hygiene between glove changes and stated they were nervous and forgot.<br><br>(continued on next page) |

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|---|---|---|---|

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| Laredo West Nursing and Rehabilitation Center | 1200 Lane Laredo, TX 78043 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | CNA A stated when they take the off the resident's brief , they clean the resident and use multiple wipes to clean the resident if needed but do not fold the wipe to use a clean surface and puts on a new breif on the resident once cleaned.<br><br>CNA A stated last in-service on hand hygiene was maybe a month a two ago but could not remember when.<br><br>Interview with DON and Administrator on 6/23/23 at 11:20am. DON stated, the expectations for hand hygiene by staff are to follow CDC guidelines. DON stated, staff should be washing hands before putting on gloves, during glove changes, and after removing gloves. Both Administrator and DON stated, hands should be washed for At least 20 seconds to prevent cross contamination and the spread of germs/infections.<br><br>During an observation on 06/23/2023 at 9:49AM, the RN A commenced the wound care by washing her hands for 8 seconds, then proceeded to set up clean supplies on R#1's bedside table. The RN A applied clean gloves, removed soiled dressing that had serosanguineous (thin, watery, pale red/pink) drainage from the sacrum area and disposed dressing. While using the same initial gloves, the RN A retrieved the clean gauze dressing that was soaked in Vashe cleaning solution and proceeded to clean utilizing several clean soaked gauzes each time. The RN A proceeded to remove dirty gloves, then applied clean gloves and packed the sacrum pressure injury with silver alginate. She then removed the contaminated gloves and applied new gloves and applied dressing. No hand hygiene was performed throughout the procedure. The RN A finished the wound care procedure by washing her hands for 12 seconds.<br><br>During an interview on 06/23/2023 at 10:05AM, the RN A stated she did not realize she only washed her hands for 8 seconds then 12 seconds. The RN A stated washing hands for less than 20 seconds could possibly lead to infecting R#1 with bacterial contaminants she may have contracted, and potentially jeopardize the resident's safety. The RN A stated she got nervous and stated she forgot to wash her hands during the wound care procedure. The RN A stated she has not had any infection control nor hand hygiene in-services, as well as not been given any competency check offs.<br><br>Record review of in-service on Hand Hygiene and Infection Control dated June 2023 beginning on 6/13/2023for all staff on the proper steps of performing hand hygiene before and after glove changes, and befer/after resident care.<br><br>Review of Policy on Infection Prevention and Control Program dated 5/13/23 states:<br><br>This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards. and guidelines.<br><br>4. Standard Precautions:<br><br>b. Hand hygiene should be performed in accordance with our facility's established hand hygiene procedures.<br><br>Review of Hand Hygiene Guidance dated 1/30/2020 states:<br><br>Immediately before touching a patient<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Before performing an aseptic task<br><br>Before moving from work on a soiled body site to a clean body site on the same patient<br><br>After touching a patient or the patient's immediate environment<br><br>After contact with blood, body fluids, or contaminated surfaces<br><br>Immediately after glove removal<br><br>Review of Handwashing-Hand Hygiene Policy dated 1/2018 states<br><br>All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.<br><br>Washing hand procedure states:<br><br>1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature.<br><br>47371 |