| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675493 | A. Building<br>B. Wing | 09/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Highland Park Care Center | 8861 Fulton St<br>Houston, TX 77022 |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059<br><br>Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 2 (Resident #1 and Resident #2) of 7 residents reviewed for resident right.<br><br>- Resident #1 did not have a privacy covering on his catheter bag.<br><br>-Resident #2 was not fully covered, and his body was partially exposed, while he was transported from his room to the shower room.<br><br>These failures could place residents at risk of decreased self-esteem and quality of life.<br><br>Finding include:<br><br>Resident #1<br><br>Record review Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility originally on 9/25/2018 and most recently on 8/9/2024. His diagnoses included unspecified dementia, acute kidney failure, acute respiratory failure, muscle weakness, and leakage of infusion catheter.<br><br>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 7 which indicated he had severe cognitive impairment. Resident #1 section for bowel and bladder revealed he had an indwelling catheter.<br><br>Record review of Resident #1's order summary report dated 9/10/2024 revealed the following:<br><br>Change foley catheter every month on the 23rd .<br><br>Observation and interview on 9/10/2024 at 10:19 a.m. revealed Resident #1 was lying in bed and his catheter bag did not have a privacy cover. Resident #1 said he was not able to see the catheter bag.<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 |
|---|---|---|

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 9/10/2024 at 10:19 a.m. revealed Resident #1 was lying in bed and his catheter bag was not covered with a privacy bag. CNA A said she the privacy covers were on the cna cart. She said she was busy and must have missed that it was not on. She said the catheter bag should be covered to maintain the resident's dignity.<br><br>Interview on 9/10/2024 at 12:00 p.m., the WC A said he was responsible for catheter care. He said he had not seen Resident #1 as he rounded this morning. He said Resident #1 should have had a privacy cover over his catheter bag. He said the cover was used to maintained Resident #1's dignity. He said he had placed covers on the CNA's supply cart and should have been available for them to use.<br><br>Resident #2<br><br>Record review of the face sheet for Resident #2 revealed a [AGE] year-old male was admitted to the facility originally on 1/7/2024 and most recently on 8/14/2024. His diagnoses included pneumonia, acute pulmonary insufficiency (lungs cannot deliver enough oxygen), epistaxis (nose bleeds, abnormal gait, muscle wasting, lack of coordination and cognitive communication deficit.<br><br>Record Review of Resident #2's quarterly MDS assessment dated [DATE] revealed the BIMS score 12 which indicated he was cognitively intact. Resident #2 used a wheelchair for mobility. Resident #2 needed maximal assist for shower/bathe (helper does more than half the effort).<br><br>Record review of Resident #2's care plan initiated date on 3/6/2024 revealed the following care plan:<br><br>Focus: [Resident #2] requires assistance with ADL care.<br><br>Goal: Efforts will be made to assist [Resident #2 with ADL care as needed next review.<br><br>Approach: 1-2 CNAs to transfer [Resident #1]<br><br>Observation and interview on 9/10/2024 at 10:25 p.m., revealed CNA A transported Resident #2 on a shower stretcher from his room on the 100 hall, past the nurses station to the 200 hall shower room. Resident #2 was sitting upright on the stretcher. A few residents were sitting at the nurse's station area as Resident #2 passed by. Resident #2 was partially covered with a bed sheet folded in half. Resident #2's abdomen and chest was exposed, and he did not have clothing on. The Surveyor followed CNA A to the shower room. CNA B said, Yes the bed sheet did not cover him, but he put his hand on the rails of the stretcher . CNA A said the bed sheet was folded in half and maybe if it was opened fully, it may have covered Resident #2 fully. She said the sheet was used to provide the resident with dignity and prevent embarrassment while he was transported to the shower room. She said it was the cna who was responsible for ensuring the resident was covered when they were transported to the shower room.<br><br>Interview on 9/10/2024 at 10:45 p.m., with the DON said staff should have completely covered the resident, so the resident was not exposed. He said the CNA that transported the resident to the shower was responsible for making sure the resident was covered. The DON said the sheet was used to protect the resident's dignity. He said he was responsible for training aides on resident rights.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 9/10/2024 at 12:00 p.m. Resident #2 said he wanted to be covered while he was transported to the shower room. He said he did not want other residents to see him without clothes on.<br><br>Interview on 9/10/24 at 2:10 p.m. with the ADON, said CNAs should transport the residents clothed and undress the residents in the shower room. She said Resident #2 should have been fully covered to maintain his dignity when he was transported to the shower room. She said she was responsible for ensuring the CNAs were trained to maintain dignity during care.<br><br>Record review of facility's policy titled Quality of Life - Dignity (updated 2/2020) revealed the following in part:<br><br>Policy Statement<br><br>Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.<br><br>Policy Interpretation and Implementation<br><br>1. Resident shall be treated with dignity and respect at all times .<br><br>10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.<br><br>11. Demeaning practices and standards of care that compromise dignity are prohibited . Helping the resident to keep urinary catheter bags covered . |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059<br><br>Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 1 (Resident #1) of 3 residents reviewed for incontinent care and for indwelling urinary catheters.<br><br>-The facility failed to ensure Resident #1's catheter stabilizer was in place.<br><br>-The facility failed to ensure Resident #1's catheter tubing was free of kinks.<br><br>These failures could place residents with urinary catheters at risk for infections and injuries.<br><br>The findings include:<br><br>Record review Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility originally on 9/25/2018 and most recently on 8/9/2024. His diagnoses included unspecified dementia, acute kidney failure, acute respiratory failure, muscle weakness, and leakage of infusion catheter.<br><br>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 7 which indicated he had severe cognitive impairment. Resident #1 section for bowel and bladder revealed he had an indwelling catheter.<br><br>Record review of Resident #1's order summary report dated 9/10/2024 revealed the following:<br><br>Change foley catheter every month on the 23rd .<br><br>Observation and interview on 9/10/2024 at 10:19 a.m. revealed Resident #1 was lying in bed and his catheter bag was not covered and the tubing was kinked in the bed frame. The urine was not flowing into the bag. CNA A moved the catheter bag from hanging on the bed frame and moved it to the hook that was supposed to hold the hanging catheter bag. CNA A said the catheter bag normally hung on a hook that extended from the bed and not on the bed frame. CNA A said the tubing was kinked in the bed frame. She moved Resident #1's tubing, it moved freely and was not secured to his leg. CNA A lifted the covers and saw the catheter stabilizer was not secured to Resident #1's thigh. CNA A said the adhesive of the stabilizer was not sticking to the resident's leg after she attempted to reapply it. CNA A said the stabilizer was used to prevent the catheter from being pulled on or out of place. She said wound care and nurses were responsible for ensuring the stabilizer was in place. She said she had not checked the catheter stabilizer or the tubing.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 9/10/2024 at 12:00 p.m. WC A said he had not seen Resident #1 when he rounded. He said Resident #1's catheter stabilizer was used to keep the catheter in place to prevent it from being pulled out and/or injury. He said he relied on the CNAs to inform him if the catheter stabilizer was not secured. He said the tubing should have been free from kinks so the urine would drain into the catheter bag. He said the resident was at risk of infection if the urine did not drain properly and injury if the tubing was not secured. He said wound care, nursing and CNAs were responsible for monitoring resident catheters. He said they should have made more frequent rounds. He said he was completing his wound care rounds and had not saw Resident #1.<br><br>Record review of facility's policy titled Catheter Care, Urinary (not dated) revealed the following in part:<br><br>Purpose: The purpose is to prevent catheter-associated urinary tract infections . Maintaining Unobstructed Urine Flow .1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing fee of kinks. Changing Catheters . 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site . |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>37059<br><br>Based on observation, interview and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 1 of 1 facility reviewed for required postings.<br><br>-The facility failed to post the daily nursing staffing information on 9/10/2024.<br><br>This failure could affect residents, facility visitors, vendors, and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner.<br><br>Findings Include:<br><br>Observation on 9/10/24 at 8:40 a.m., during entrance revealed the nursing staffing information was posted at the receptionist desk dated 9/8/2024.<br><br>Observation on 9/10/24 at 12:10 p.m., during rounds revealed the nursing staffing information was posted at the receptionist desk dated 9/8/2024.<br><br>Interview on 9/10/24 at 12:13 p.m., with the Receptionist, she said she was responsible for posting the daily nursing staff information at the front desk. She said she forgot to update it for the past two days. She said the information was posted to let the public and others know the staffing on each shift and the census.<br><br>Interview on 9/10/24 at 12:16 p.m., with Staffing Coordinator, she said the receptionist was responsible for the daily nurse staffing posting at the front desk. She said the nurse staffing should be updated daily.<br><br>Interview on 9/10/24 at 1:10 p.m., the DON said the receptionist along with the staffing coordinator were responsible for the daily nursing posting. The DON said the daily nursing staffing was supposed to be posted at the front of the facility each day.<br><br>Interview on 9/10/2024 at 1:15 p.m. the facility staffing posting policy was requested from the DON and was not received at the time of exit. |