

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Woodland Park Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Woodland Park Dr Shepherd, TX 77371	

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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115</p> <p>Based on interviews and record review, the facility failed to ensure appropriate information was communicated to the receiving health care institution or provider for 1 of 3 residents (Resident #1) reviewed for discharge communication documentation.</p> <p>Resident #1 was discharged to her home on 07/06/24. She did not receive home health services until 07/09/24. The facility did not ensure the HHA received the required information prior to Resident #1's discharge.</p> <p>This failure placed residents at risk of not receiving necessary care and services.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 07/12/24 indicated she was a [AGE] year old female admitted on [DATE] and her diagnoses included sepsis (the body's extreme reaction to an infection), cerebral infarction (stroke), malignant neoplasm of overlapping sites of left breast (cancerous tumor), diabetes (high blood sugar), acute kidney failure (unable to filter waste products from the blood), and unspecified multiple injuries.</p> <p>Record review of Resident #1's baseline care plan dated 06/20/24 indicated Resident #1's goals included improve ADL skills, increase continence to achieve discharge plan, and planned to discharge home.</p> <p>Record review of a social service note dated 06/24/24 at 8:56 a.m., completed by ADMK B indicated Resident #1 was admitted to the facility on short-term rehabilitation. Resident #1 planned to discharge home with home health services.</p> <p>(continued on next page)</p>

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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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's 5-day MDS dated [DATE] indicated she was usually understood, had severe cognitive impairment (BIMS score 3), required extensive assistance of 2+ person physical assist for bed mobility and was totally dependent on 2+ person physical assist for toileting. She had one or more unhealed pressure ulcers/injuries. Her Skin and Ulcer/Injury Treatments included a pressure reducing device for her bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressings, and applications of ointments/medications other than to feet. Resident #1's overall Goal was to discharge to the community. Resident #1 wanted to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. A referral to local contact agency was not made was marked as unknown.</p> <p>Record review of Resident #1's physician orders dated 07/05/24 indicated discharge home 07/06/24 with home health.</p> <p>Record review of Resident #1's Final Transfer/Discharge from the facility dated 07/06/24 indicated Resident #1 was discharged home. Her diagnoses included sepsis and buttock wound and all medications were sent with Resident #1 and RP. She had a Foley catheter. She was at risk for falls, limited/non-weight bearing, needed medications crushed and Flagyl (antibacterial agent) was crushed and applied to buttock wound daily. Pressure ulcers covered both buttocks with foul drainage. She had impaired cognition and sensation. She was incontinent of bladder and bowel. HHA referral was checked YES. Provision of current Reconciled medication list to subsequent provided at discharge was checked as paper based (e.g. fax, copies, printouts).</p> <p>Record review of Resident #1's discharge summary fax cover sheet dated 07/03/24 indicated the summary was faxed to an HHA on 07/03/24. The fax cover sheet indicated sending is complete. The HHA's fax number noted on the fax sheet had an extra 6 in the number typed into the facility's fax machine and was not the correct HHA number.</p> <p>During an interview on 07/12/24 at 8:17 a.m., a family member said the facility had not sent Resident #1's discharge information to the HHA or arranged services. She said Resident #1 was discharged home on 07/06/24 with no medical equipment and no nurse services. She said Resident #1 received no services for two days after she was discharged from the facility because the HHA had not received Resident #1's discharge information.</p> <p>During an interview on 07/15/24 at 12:25 p.m., ADMK B she was responsible for completing the discharge process. She said she faxed Resident #1's discharge summary to the HHA on 07/03/24. She said she was not aware the HHA had not received Resident #1's discharge information until 07/09/24. She said she received a text from HHA CM C on 07/09/24 saying he had not received Resident #1's information. She said Resident #1 was discharged home on 07/06/24 with the HHA number and HHA CM's number to call if the HHA's staff did not arrive to provide service. She said she was not aware she had input the wrong number into the facility's fax machine. She said she thought the confirmation the fax was sent meant the receiving facility had received the information. She said it was important to ensure the HHA or other receiving provider received a resident's information to ensure continuity of care.</p> <p>During an interview on 07/15/24 at 11:43 a.m., HHA MDM A said the facility faxed Resident #1's discharge summary to the HHA on 07/09/24. She said the HHA had no information from the facility prior to 07/09/24.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/15/24 at 12:33 p.m., HHA CM C said he texted ADMK B on 07/09/24 when he was not able to locate Resident #1's discharge information. He said ADMK B had notified him on 07/03/24 of Resident #1's pending discharge and said she would send Resident #1's information. He said he received Resident #1's discharge information on 07/09/24 and nursing staff was sent out STAT on 07/09/24.</p> <p>During an interview on 07/15/24 at 12:45 p.m., the DON said she was not aware the HHA had not received Resident #1's information. She said she was not aware the fax cover sheet that indicated information sending was completed, did not confirm the receiving facility had received the information. She said it was important to ensure the HHA or other receiving provider received a resident's information to ensure continuity of care.</p> <p>Record review of the facility's Transfer or Discharge documentation policy dated 2001 (revised December 2016) indicated .2. Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: a. The basis for the transfer or discharge; (l) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: (a) the specific resident needs that cannot be met; (b) this facility's attempt to meet those needs; and (c) the receiving facility's service(s) that are available to meet those needs. b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance Directive information; e. All special instructions or precautions for ongoing care, as appropriate; f. Comprehensive care plan goals; and g. All other necessary information , including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p>		