

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER West Janisch Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 617 W Janisch St Houston, TX 77018	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469</p> <p>Based on observation interview and record review, the facility failed to ensure comprehensive care plans with the services that are to be furnished to attain or maintain the resident's highest practicable physical well-being were developed for 2 of 3 residents (Resident #34 and #28) reviewed for care plans, in that:</p> <p>Resident #34 and #28, who were both identified as high risk for falls and in need of fall mats, did not have the intervention of fall mat included in their care plans.</p> <p>This failure places residents at for not receiving adequate care.</p> <p>Findings included:</p> <p>Resident #34</p> <p>Record review of Resident #34's face sheet reflected a [AGE] year-old female who was admitted into the facility on [DATE] and was diagnosed with hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>Record review of the facility incident log reported, dated 03/10/2024 - 09/10/2024 revealed the Resident #34 had three falls in the past six months, on dates 07/14/2024, 08/03/2024 and 08/07/2024.</p> <p>Record review of Resident #34's care plan reflected the resident was care planned for falls and documented to have an actual fall that occurred on 08/07/2024 but did not include the intervention of a fall mat.</p> <p>Record review of Resident #34's quarterly MDS, dated [DATE], reflected the resident did not have any falls since their prior assessment upon admission.</p> <p>Observations on 09/12/24 at 11:54AM, revealed Resident #34 lying in bed with a fall mat to the side of her bed.</p> <p>Record review of Resident #28's face sheet reflected a [AGE] year-old female who was admitted into the facility on [DATE] and was diagnosed with dementia and metabolic encephalopathy.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility incident reported, dated 03/10/2024 - 09/10/2024 reflected the Resident #28 had on fall that occurred on 07/28/2024.</p> <p>Record review of Resident #28's nurses notes reflected the resident on 09/06/2024, that the resident slid off her bed and fell on to the fall mat.</p> <p>Record review of Resident #28's care plan, not dated, reflected the resident was care planned for falls and documented to have an actual fall that occurred on 07/28/202, but did not include the intervention of a fall mat.</p> <p>Record review of Resident #28's admission MDS, dated [DATE], reflected the resident did not have any falls since their admission.</p> <p>In an interview with CNA T on 09/12/24 at 12:00PM, who stated he usually worked often with Residents #34 and #28. He stated he referenced a chart or kiosk to know who needs a fall mat. He stated Resident #34 tended to swing herself to the right while sleeping causing her to slide off the bed and Resident #28 would sometimes throw herself off the bed. If the fall mat was not placed for both of the residents, they could possibly be injured in a fall.</p> <p>In an interview with LVN E on 09/12/24 at 12:08PM, who stated she worked frequently with Resident #34 who rolled out of her bed. She said they keep a wedge to prevent her from rolling off the bed, kept fall mats in place and the bed low. She stated Resident #34 did fall on the end of her shift once. She also said Resident #28 had a history of being confused and rolling herself out of the bed. The fall mat was there when she fell , and she did not have any major injury as a result. She stated the interventions should be listed on the care plan, and because she was new, she would not have known if the fall mat if she did not already see it placed on the floor when she came in. She stated nurses were to at least verbally report needs of patients to the nursing team and bring up pertinent information such as interventions at the morning meetings for the MDS or another staff to note and update the care plan. She said without fall mats residents can experience an increased risk of injury of the head.</p> <p>In an interview with the DON on 09/12/24 12:41PM, who stated that her and the Administrator were responsible for updating the care plans to add new information and resolved interventions that are no longer applicable. Residents can change, they need to keep the care plan interventions updated and they can also attach the task attached to the kardex (desktop file system) for the CNAs to reference it as well. Fall mats should have been on the care plan. She stated Resident #34 and #28 both need fall mats, or else they would injure themself in fall.</p> <p>Record review of the facility's policy on Care Plan Revisions Upon Status Change, not dated, reflected, . The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change . The care plan will be updated with the new or modified interventions .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392</p> <p>Based on observations, interviews and record review, the facility failed to ensure all drugs and biologicals were stored securely for one of two medication carts reviewed for medication storage.</p> <p>The facility failed to keep resident medications in their original containers/packaging located in the medication cart assigned to LVN M. There were 18 loose pills at the bottom of one of the drawers belonging to unknown residents.</p> <p>These failures could affect residents receiving medications placing them at risk of receiving the wrong medication and adverse side effects.</p> <p>Findings included:</p> <p>During observation and interview on [DATE] at 2:45PM, the medication aide cart for the skilled unit which was assigned to LVN M had 18 loose pills of various shapes, sizes, and colors at the bottom of the second drawer from the left of the cart. The loose pills were underneath the medication blister cards that were tightly packed together. LVN M stated her role for the day was to administer medications that were usually assigned to a medication aide. LVN M stated she was responsible to keep the medication cart clean and ensure there were no expired meds and no loose pills. LVN M stated the potential issues were allergic reaction to a resident if loose pills fall out onto the floor and a resident takes it. LVN M stated she did not know but would check with DON on how to dispose of the loose pills.</p> <p>During an interview on [DATE] at 3:15PM the DON who stated the charge nurses, DON and ADON were responsible to check med carts. The DON stated the risks to having loose pills would be not knowing exactly what the pills were for and if a resident were to get a hold of loose pills it could cause side effects, it could cause harm, vital signs could drop, and heart rate could increase. The DON stated the medication supply could run out for that resident and a refill order would have to be placed. The Regional Nurse Consultant stated there would be no extra cost to the resident when reordered. The Regional Nurse Consultant stated that at times pills tend to fall out of blister cards d/t pharmacy packaging when cards are removed or replaced back into the cart.</p> <p>During an interview on [DATE] at 8:30AM, the DON who stated that LVN M did come to her after the loose pills were found and she instructed LVN M to crush the pills then put them into the sharps container. The DON stated, during audits, she ensured carts are checked, that over-the-counter medications were dated, insulins were dated accordingly, blister cards were not ripped, foil intact and made sure liquid medications were not leaking. She stated the DON would do audits weekly and the pharmacist checked carts monthly. The DON stated moving forward, she will check carts more often, conduct in-services for the nurses and medication aides, lift everything out cart and check bottom of drawers for loose pills.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the undated facility policy and procedures for Medication Storage read in part: .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and /or medications rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation .and security All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) .</p>		