| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675651 | A. Building<br>B. Wing | 04/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| San Marcos Rehabilitation and Healthcare Center | 1600 N I H 35<br>San Marcos, TX 78666 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949<br><br>Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible for one (Resident #1) of four residents reviewed for accidents hazards, in that:<br><br>The facility failed to ensure all rough edges of Resident #1's bed frame were covered, resulting in a laceration to his left leg during a transfer.<br><br>This failure could place residents at risk of pain, bruising, or skin tears.<br><br>The findings included:<br><br>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type II diabetes, acquired absence of unspecified leg below knee, bullous pemphigoid (a rare skin condition that causes large, fluid-filled blisters), and chronic pain.<br><br>Review of Resident #1's admission MDS assessment, dated 03/13/24, reflected a BIMS of 15, indicating no cognitive deficits. Section N (Medications) reflected he was taking an anticoagulant (blood thinner) and an antiplatelet (prevents blood clots).<br><br>Review of Resident #1's admission care plan, dated 04/10/24, reflected he had diabetes with an intervention of checking all of body for breaks in skin and to treat promptly as ordered by doctor.<br><br>Review of Resident 1's progress note, dated 04/09/24 at 1:43 PM and documented by LVN A, reflected the following:<br><br>PT staff noted a skin alteration to Lateral LLE upon transfer [sic] [Resident #1] to bed.<br><br>Review of Resident #1's progress note, dated 04/10/24 at 4:09 PM and documented by LVN B, reflected the following:<br><br>(continued on next page) |



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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | [Resident #1] noted this AM with gauze wrapped around LLE with large amount of blood, this nurse removed gauze, noted a laceration 11x1, cleansed area, applied new gauze to laceration, notified PA, new order to send [Resident #1] to (hospital) to eval and treat . [Resident #1] arrived back at facility at 12:45 (PM) with new orders to keep clean and dress wound daily .<br><br>Review of Resident #1's Change in Condition Evaluation, dated 04/10/24, reflected the following:<br><br>Situation: skin wound or ulcer<br><br>Evaluation: lateral left lower extremity open with moderate amount of blood<br><br>Pain Evaluation: [Resident #1] with a pain scale of 7<br><br>Summary: Moderate amount of blood noted to bandage covering laseration [sic], cleansed area, redressed wound, sent [Resident #1] to hospital<br><br>Review of Resident #1's ER Discharge Instructions, dated 04/10/24, reflected the following:<br><br>Discharge Diagnosis: Laceration of left lower extremity<br><br>Patient Instructions: Follow up with (plastic surgeon) in one week, 04/17/24<br><br>Review of Resident #1's PRN/Weekly Skin Evaluation, dated 04/11/24, reflected a laceration to the front left lower leg, measuring 11 cm x 3.5 cm.<br><br>During an observation and interview on 04/15/24 at 11:02 AM, revealed Resident #1 lying in bed. He stated he did remember the incident from 04/09/24. He stated he was done with physical therapy and two of the therapists were transferring him from his wheelchair to his bed. He pointed to a metal pole on the end of his bed and stated that the black cap that was covering the pole was not on there at the time. He stated his leg dragged against it during the transfer and it ripped his leg open. He stated he did not feel it when it happened, but after he was in a lot of pain. He stated he just had his right leg amputated and his doctor told him to not bear any weight on his left leg for three weeks due to the laceration. He stated it was frustrating and had caused him a lot of pain.<br><br>During an interview on 04/15/24 at 11:46 AM, PTA C stated he and another therapist were transferring Resident #1 from his wheelchair to his bed on 04/09/24. He stated Resident #1 did not complain of pain during the transfer, but once he was on his bed, he stated that his leg felt funny. He stated he looked down and saw the wound/skin tear and a lot of blood. He stated he looked at the bed frame and saw there was a missing cap on one of the metal pipes. He stated that he compared the location of the pipe to the location of the tear and could tell that it was the pipe that caught his leg. He stated he felt the pipe and compared it to a pipe with the cap on and it was much sharper with the exposed metal.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 04/15/24 at 12:04 PM, the DON stated she was notified Resident #1 had sustained a skin tear on his left calf during a transfer from his wheelchair to his bed when his leg rubbed against the bed frame. She stated she was told a cap was missing on one of the pipes. She stated because Resident #1's skin was so fragile, his skin could have torn with or without the cap. She stated potential harm for someone who was diabetic and sustained a skin tear would be possible infection.<br><br>A telephone message was left on 04/15/24 at 12:13 PM for LVN A. A response was not received prior to exit.<br><br>During an interview on 04/15/24 at 12:44 PM, LVN B stated that she was informed that when therapy was transferring Resident #1 on 04/09/24, the metal part of the bed frame hit his left leg and opened it up. She stated his skin was so fragile that it would not have mattered if the cap was on it or not. She stated on 04/10/24 in the morning she noticed the gauze was covered in blood. She stated she assessed the wound and it was a nasty laceration and deep enough that she believed it needed to be sutured or glued shut . She stated she sent him to the ER but they did not do anything or send any new orders.<br><br>During an interview on 04/15/23 at 12:56 PM, the MAINTD stated after Resident #1 acquired his skin tear, he was asked to inspect his bed and noticed the cap was missing on one of the rails. He stated it was everyone's responsibility to make sure the caps were on and secured. He stated the importance of the caps were to cover the pipes like a plug which helped with skin protection. He stated he conducted a sweep of the beds in the facility and found no others missing . He stated staff were aware that he had extras should one pop off.<br><br>Review of the facility's Mechanical Equipment Policy, revised 07/2018, reflected the following:<br><br>It is the policy of this facility to make safety a priority for both residents and staff. Potentially dangerous mechanical equipment will be handled to ensure safety.<br><br>Procedure:<br><br>1. All recommended safeguards will be implemented for potentially dangerous mechanical equipment .<br><br>2. Potentially dangerous mechanical equipment will be properly installed, tagged, and inspected on a regular basis in order to avoid safety issues for residents and staff. |