Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675913	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pflugerville Care Center	521 S Heatherwilde Blvd Pflugerville, TX 78660

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observations, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for two (Resident #1 and Resident #2) of three residents reviewed for quality of care. The facility failed to identify bruising and changes in skin for Resident #1 and Resident #2. This failure could place residents at risk of not receiving necessary medical care, harm, and hospitalization . Findings included: Review of Resident #1's face sheet revealed an [AGE] year-old man admitted on [DATE] with diagnoses of unspecified dementia (mild cognitive impairment not yet diagnoses as a specific type of dementia), thrombocytopenia (a condition where a person has a low number of platelets in their blood, which can lead to excessive bleeding), and cognitive communication deficit (a communication impairment that's caused by an underlying cognitive deficit, rather than a speech or language deficit). Review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment. Review of Resident #1's care plan dated 04/30/2024 revealed Resident #1 will have intact skin, free of redness, blisters, or discoloration. Review of Resident #1's skin observations from 10/16/2024 to 10/23/2024 revealed no scratches, red areas, discoloration, skin tears, or open areas were selected. Review of Resident #1's nursing progress notes dated 09/28/2024 to 10/23/2024 revealed no notes regarding skin changes. Review of Resident #1's weekly skin assessment dated [DATE] revealed the resident had a pressure, venous, arterial, or diabetic ulcer. A bruise and blister were not selected on this assessment. Review of Resident #1's physician orders revealed no orders for the right middle finger treatments. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's face sheet revealed an [AGE] year-old woman admitted on [DATE] with diagnoses of unspecified dementia (mild cognitive impairment not yet diagnoses as a specific type of dementia), and cognitive communication deficit (a communication impairment that's caused by an underlying cognitive deficit, rather than a speech or language deficit). Review of Resident #2's quarterly MDS revealed a BIMS score of 3 which indicated severe cognitive impairment. Review of Resident #2's care plan dated 08/07/2023 revealed Resident #2 will have intact skin, free of redness, blisters, or discoloration through review date. Review of Resident #2's skin observations dated from 10/16/2023 to 10/23/2024 revealed no scratches, red areas, discolorations, skin tears, or open areas were selected. Review of Resident #2's nursing progress notes dates 10/06/2024 to 10/23/2024 revealed no notes regarding skin changes. Review of Resident #2's weekly skin assessment dated [DATE] revealed the resident had no abnormalities in skin and signed on 10/22/2024. Review of Resident #2's weekly skin assessment dated [DATE] revealed an assessment was changed to include a bruise on the left thumb and left arm/wrist for a skin tear and signed on 10/23/2024. Review of the facility incident reports for October 2024 revealed no incidents noted for Resident #1 and Resident #2. Review of the facility skin report dated 09/25/2024 to 10/23/2024 revealed no skin issues noted for Resident #1 and Resident #2. Observation on 10/23/2024 at 10:24 AM revealed Resident #1 in the memory care unit. Further observation revealed a circle blister dark purple in color on his right middle finger. The resident appeared pleasantly confused with no pain. Observation on 10/23/2024 at 10:35 AM revealed Resident #2 in the memory care unit. Further observation revealed a bruise on the left wrist with an undated bandage on the left mid-arm. The resident was confused and did not appear in pain. During an interview on 10/23/2024 at 10:35 AM, Resident #2 stated she was unsure what happened to her hand and why she had a band aide. Resident #2 stated that it did not hurt. During an interview on 10/23/2024 at 10:33 AM, LVN D stated she did not know what was on Resident #1's right hand. LVN D reviewed Resident #1's chart and stated that there was no documentation in his chart about it and nothing on his skin assessment. LVN D stated that she would have to let the DON know. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/2024 at 12:42 PM, LVN D stated she was not sure what Resident #2's bruise was from or why she had a bandage on. LVN D stated there was not information regarding Resident #2's skin issues on her left hand in her chart. LVN D stated that there should have been a nurses note and skin assessment for any bruising or reason for a bandage being put on. LVN D removed Resident #2's bandage and stated that Resident #2 had a skin tear. During an interview on 10/23/2024 at 12:47 PM, CNA A stated that if she noticed any changes to a resident's skin, she would report it to a charge nurse immediately. She stated that if she did not report it the resident could be in pain. During an interview on 10/23/2024 at 12:48 PM CNA B stated that if she noticed a skin tear or bruise on a resident, she would let the nurse know immediately. CNA B stated that it was important to notify the nurse so that they can figure out what happened. CNA B stated that any skin issues were documented in the resident's POC under skin observation. During an interview on 10/23/2024 at 12:55 PM CNA C stated if she noticed any changes in a resident's skin such as a skin tear or bruise, she would report it to the nurses. CNA C stated it was important to report it right away so staff would notice if anything new happened over shift to shift. CNA C stated that she was required to document any changes in the resident's POC such as redness or changes in skin. During an interview on 10/23/2024 at 12:59 PM, RN G stated if she noticed any changes in a resident's skin, she would check orders for treatment. RN G stated if it was new, she would notify the NP if there were any signs or symptoms. She stated she would put a progress note, any intervention, and would document what the new skin issues were such as if it was a bruise or skin tear. She stated she would notified the DON/NP and resident's family RN G stated she would complete a skin assessment and would do an incident report. RN G stated it was important to document any changes because the facility was responsible for the care of the residents and the staff had a responsibility to report anything and everything. RN G stated it was important to document to note any changes from one shift to another so staff were aware. RN G stated after interventions are completed documentation should be completed shortly after. During an interview on 10/23/2024 at 1:06 AM, LVN E stated that if she noticed any changes in a residents' skin, she would notify wound care if it was new. LVN E stated she would notify wound care after she assessed the resident's skin. LVN E stated she would get measurements of the bruise and describe what it was in the note. LVN E stated she would complete an incident report, notify the family, the DON, and the NP and complete a progress note about any findings. LVN E stated she would note any changes of the skin in the progress note and incident. She stated it was important to document so it could be followed up on and to follow for any signs or symptoms and so other staff were aware. During an interview on 10/23/2024 at 1:14 PM, NP F stated that she would not necessarily have expected the facility to notify her of any new bruising or skin issues unless it was significant in size. She stated she would expect to be notified if the resident had a new blood blister because she would not want it to be popped. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/2024 at 2:55 PM, the DON stated it was her expectation to complete a skin assessment, SBAR, notify the NP, and get an order if needed when changes were noted to a resident's skin. The DON stated if it was a wound, then it would need follow up by the wound care doctor. The DON stated if there was a change of condition the nurse should have completed an SBAR and an incident report. The DON stated a skin tear should be noted in the resident's chart. The DON stated that if the resident has something on the skin for a long time and it was reopened, they should still notify the DON and from there a skin assessment should be completed. The DON stated it was important to document changes so staff could try to ask the resident what happened so they could investigate. The DON stated if staff did not notify of changes, they would not know the patient had a dressing or changes in skin. During an interview on 10/23/2024 at 3:05 AM, the ADM stated he expected staff to report and document changes in resident's skin. The ADM stated this included to complete an incident report, notification to physician, the responsible party and a skin assessment and progress note. The ADM stated that those all tie in together. The ADM stated that if changes were not reported they could get worse, and the facility wants to ensure there was a correct treatment plan. The ADM stated skin assessment findings should correlate with the day they were completed. The ADM stated they do not have a quality-of-care policy. Review of in-service dated 10/14/2024 revealed topics included resident's assessment completed in a timely manner and included UDAs. Review of facility policy titled Notifying the Physician of Change in Status dated March 11, 2013, revealed the nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.