| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676315 | A. Building<br>B. Wing | 06/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Hillcrest of North Dallas | 18648 Hillcrest Rd<br>Dallas, TX 75252 |

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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** 44405<br><br>Based on interview and record review, the facility failed to ensure a resident with urinary incontinence, based on the resident's comprehensive assessment, who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 (Resident #1) of 7 residents reviewed for Urinary Tract Infection (UTI), in that:<br><br>The facility failed to ensure physician's orders were in place for care and management of a female external urinary collection system or implement a Urinary Toileting Program(s).<br><br>These failures could put residents at risk of poor personal hygiene, impaired skin integrity, and decreased feelings of self-worth and dignity (how the reasonable person would react under such circumstances).<br><br>Findings Included:<br><br>A record review of Resident #1's Admission MDS assessment dated [DATE] revealed an [AGE] year-old female admitted on [DATE]. Resident #1 had history and diagnoses of CKD Stage 3B (kidneys have mild to moderate damage and are less able to filter waste and fluid out of the blood), Unspecified Diastolic CHF, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Lower Extremity, Bilateral; Unspecified Urinary Incontinence; DM and Cognitive Communication Deficit. A BIMS score of 15, suggested Resident #1 was cognitively intact. Resident #1 had no behavioral symptoms or rejection of care behavior during the MDS review period. Resident #1 exhibited Rejection of Care behavior(s) that occurred 1 to 3 days. Resident #1's functional status reflected one-person substantial/maximal assistance to shower/bathe self, upper body dressing, and toileting hygiene. The Admission MDS Assessment reflected Resident #1 used an external catheter appliance. The Admission MDS Assessment did not reveal any infections or UTI in the last 30 days.<br><br>Record review of Resident #1's comprehensive care plan initiated 04/13/24 (Next Review Date: 06/09/24) reflected:<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 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [Resident #1] was non-compliant with care r/t Anxiety - refuses incontinent care; refuses wipes used for incontinent care, prefers warm wash cloths; and refuses to use PureWick catheter [entered 06/09/24]. The intervention(s) included Notify family and physician of behavior/refusal of care; Praise resident for a cooperative attitude towards acceptance of meds; Report refusal to supervisor; and Talk to resident to determine reasons for refusal of care. The long-term goal indicated . needs will be met during the next 90 days. (Initiated on 04/18/24; Revision on 04/30/24; Target Date: 06/09/24).<br><br>[Resident #1] had functional bladder incontinence . overactive bladder. The interventions included Brief Use: disposable briefs; Encourage fluids during the day to promote voiding; Ensure unobstructed path to the bathroom; Monitor/document s/sx UTI; Monitor/document/report to MD PRN possible medical causes of incontinence. The long-term goal indicated . will remain free from skin breakdown due to incontinence and brief use through the review date. (Initiated on 04/30/24; Target Date: 06/09/24).<br><br>[Resident #1] uses anti-anxiety medications r/t Adjustment issues. The interventions included Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. The long-term goal indicated . will show decreased episodes of s/sx of anxiety through the review date. (Initiated on 05/17/24; Target Date: 06/09/24).<br><br>[Resident #1] had (PureWick Catheter): Skin Breakdown. The intervention(s) included Check tubing for kinks and maintain the drainage bag off the floor; Monitor for s/sx of discomfort on urination and frequency; Monitor/document for pain/discomfort due to catheter. The long-term goal indicated [Resident #1] will show no s/sx of urinary infection through review date. (Initiated on 06/08/24; Target Date: 06/09/24).<br><br>[Resident #1] had an ADL Self Care Performance Deficit r/t Activity intolerance, Disease Process (CHF). The intervention(s) included [Resident #1] requires (substantial/maximal assist x1) staff participation to reposition and turn in bed, with bathing, to turn and reposition, and personal hygiene/oral care. The long-term goal indicated [Resident #1] will improve/maintain current level of function . through the review date. (Initiated on 04/13/24; Revision on 04/30/24; Target Date: 06/09/24).<br><br>Review of Resident #1's physician's orders indicated:<br><br>Order Date 04/12/24: Miconazole 7 Vaginal Cream 2% (used to treat vaginal yeast infections). Insert 1 applicator vaginally two times a day for Infection for 30 days.<br><br>Order Date 04/13/24: Nystatin (Antifungal used to treat fungal or yeast infections on the skin) External Ointment 100000 unit/gm. Apply to breasts, ABD fold, groin topically every 12 hours as needed for redness.<br><br>Order Date 04/15/24: Lasix (A strong diuretic used to treat excessive fluid accumulation [edema]) oral tablet 40 mg. Give 1 table by mouth one time a day for Heart failure.<br><br>Order Date 05/07/24: One time UA for cloudy urine.<br><br>Order Date 05/07/24: Apply Triad Paste every shift 3 times a day. Every shift. [D/C Date: 05/22/24].<br><br>Order Date 05/09/24: Urinalysis with C&S to r/o UTI one time only for mild pain and Odor.<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 | Order Date 05/10/24: Macrobid (Antibiotic for treatment and prevent urinary tract infections) 100 mg 1 capsule by mouth STAT; then, give 1 capsule by mouth two times a day for UTI for 5 days.<br><br>Order Date 05/12/24: Lorazepam Oral Concentrate 2 mg/ml. Give 1 ml sublingually every 2 hours as needed for anxiety. [D/C Date: 06/08/24].<br><br>Order Date 05/12/24: Lorazepam Oral Concentrate 2 mg/ml. Give 0.5 ml sublingually every 2 hours as needed for anxiety. [D/C Date: 06/08/24].<br><br>Order Date 05/22/24: Zinc oxide barrier cream to buttocks for preventive measures every shift.<br><br>Order Date 05/24/24: STAT UA with C&S. [D/C Date: 05/30/24].<br><br>Order Date 05/29/24: Miconazole Powder (Antifungal powder to treat fungal or yeast infections on the skin). Apply to groin topically every day shift for rash.<br><br>Order Date 05/30/24: STAT UA with C&S for abdominal pain.<br><br>Order Date 05/31/24: Macrobid 100 mg 1 capsule by mouth every morning and at bedtime for UTI.<br><br>Resident #1's physician orders did not reflect management of the PureWick System (female external urinary catheter) or Urinary Toileting Program.<br><br>Record review of Resident #1 Weekly Wound Progress assessments dated 05/07/24 revealed the WMD was notified of a non-pressure wound of the left buttocks. Record review of the WMD Initial Wound Evaluation and Management Summary dated 05/07/24 reflected Resident #1 presented with a wound on left buttock and rashes. The WMD identified a non-pressure wound of the left buttock caused by Moisture Associated Skin Damage [MASD] (caused by prolonged exposure to various sources of moisture, including urine or stool) - stool moisture, in place for greater than 3 days. The WMD recommended a Hydrocolloid Paste (Zinc-oxide based hydrophilic [water resistant] paste for light-to- moderate levels of wound exudates) applied every shift (3 times a day) for 30 days treatment plan and recommended to Off-load wound, reposition per facility protocol, turn side to side in bed every 1 - 2 hours if able, and limit sitting to 60 minutes. The Hydrocolloid Paste scheduled for thirty days to help maintain a wound healing environment was discontinued on 05/22/24.<br><br>Record review of Resident #1 Weekly Wound Progress assessments dated 05/21/24 revealed Resident #1 had a non-pressure wound of the left buttocks was resolved and healed. Record review of Resident #1's Weekly Skin Check assessment dated [DATE] the staff did not identify any skin impairment(s). The Weekly Skin Check assessment dated [DATE] revealed Resident #1 had redness on buttocks.<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 | During an observation and interview on 06/08/24 at 12:47 PM, revealed there was a foul-smelling urine odor upon entering Resident #1's room. Resident #1 was observed sitting up in bed prepared to perform self-perineal care with a washcloth in both hands and a basin filled with water on the bed between her legs. CNA B was standing at the bedside. A PureWick drainage collection canister was noted at the bedside placed on a nightstand lined with a plastic trash bag. The collection canister (2000 cc capacity) did not have a privacy cover and was filled slightly above the 1000 cc mark with dark yellow, cloudy urine. The foul-smelling urine odor was stronger when Resident #1's bedside (where the collection canister sat on the nightstand) was approached. The tubing was connected to the canister port, twisted, looped, and the end of the collector tubing that the PureWick External Catheter connected was placed in the nightstand drawer. CNA B could not verbalize what the drainage system was sitting at the bedside, who was responsible, or how often the canister was emptied. Resident #1 declined observation of ADL/peri-care by self [Resident #1] and CNA B as needed.<br><br>During an observation and interview on 06/08/24 at 1:08 PM, revealed CNA B was placing a disposable brief on Resident #1. CNA B asked Resident #1 to turn to the side [Resident #1's right lateral side] as CNA B walked to the left side of the bed, behind Resident #1. Resident #1 placed her left hand on the right-side bed rail, partially turning only her upper body. CNA B pushed on Resident #1's hips and left buttocks to pull the brief out from under [Resident #1's] back side. Resident #1's legs shifted toward the edge of the bed due to being inappropriately repositioned when CNA B pushed on Resident #1's hips and left buttocks. Resident #1 verbalized feelings of discomfort when CNA B pushed on [Resident #1's] hips, buttocks, and fear of sliding off the bed. Resident #1 verbalized feeling rushed and asked CNA B to wait or hold on. CNA B told Resident #1 that she was not going to fall and that she had her [implied that CNA B supported Resident #1 and would not allow her to fall off the bed]. CNA B adjusted the disposable brief and instructed Resident #1 to lay back flat. CNA B walked back to the right side of Resident #1's bed and pushed on Resident #1's inner left knee and thigh to spread her legs to pull the brief between [Resident #1's] legs. Resident #1 presented with large raised patchy dark pink and reddened areas across her perineal area, buttocks, and upper inner thighs. Resident #1 grimaced and expressed mild discomfort when CNA B pressed at the left inner thigh. Resident #1 suggested another way to reposition her legs without pressing on them that caused discomfort. CNA B said that she was not pressing on her or hurting [Resident #1]. CNA B said that she would apply cream (barrier cream) to the red areas to make Resident #1 feel better. Resident #1 said that CNA B was hurting her vagina when she applied the cream and directed CNA B where to apply the cream. Interview with Resident #1 indicated she was alert and oriented to self, situation, surrounding and time of day. Resident #1 was cooperative with interview and indicated a bladder training program was not offered. Resident #1 stated that she wore the PureWick External Catheter System all day and night with a brief.<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 | During an interview on 06/08/24 at 1:15 PM, CNA B said that she worked on the weekends and was assigned to Resident #1. CNA B indicated Resident #1 was a one-person assist with incontinence care. CNA B be could not explain the use of or verbalize management or care needs related to the PureWick External Catheter System. CNA B said that staff should provide incontinence care at least every two hours or sooner if needed. CNA B stated checking and changing residents who were incontinent every two hours kept residents comfortable and prevented skin breakdown. CNA B denied knowledge of or the need to assist Resident #1 with an individualized toileting program to prevent a UTI or skin breakdown. CNA B said that the barrier cream that she applied was to help prevent skin breakdown. CNA B could not verbalize the difference of redness of the area or if it was a rash. CNA B could not indicate if the barrier cream, she applied improved or could worsen the large patchy dark pink and reddened areas across perineal area, buttocks, and upper inner thighs noted on Resident #1. CNA B said that she would inform the nurse for assessment and to determine treatment.<br><br>During an interview on 06/08/24 at 1:30 PM, LVN A indicated she had not checked on Resident #1 since change of shift (6:30 AM). LVN A said that all nursing direct care staff (nurses, CNAs) should empty the PureWick External Catheter collection canister if it appeared full. LVN A could not verify how often the collection canister should be emptied and denied the need to document urine output. LVN A could not verify how frequent the PureWick External Catheter System should be changed or the timeframe it should be in place/or removed but stated that Resident #1 kept the external catheter system in place all the time. LVN A stated reportable signs of a possible UTI and indicated that Resident #1 received an antibiotic treatment for a current UTI. LVN A could not verbalize management or care needs related to the PureWick External Catheter System. LVNA denied knowledge of or the need to assist Resident #1 with an individualized toileting program to prevent a UTI or skin breakdown. LVN A said that staff applied a barrier cream to Resident #1 perineal, buttocks, and inner thighs to help prevent skin breakdown of the reddened areas.<br><br>Observation on 06/08/24 at 2:05 PM revealed LVN A approach Resident #1 to change the external catheter on the PureWick External Catheter System. LVN A and CNA B provided incontinent care.<br><br>Observation and interview on 06/09/24 at 11:33 AM revealed the DON conducted rounds and checked on Resident #1. Resident #1 indicated that she received incontinence care, was clean, and dry. The external catheter collection canister had <400 cc dark yellow, cloudy urine. Resident #1 denied concerns at this time. During an interview, the DON stated that he checked on residents daily in the morning or if time permitted, would check on residents again before he left for the day. The DON stated the propose of checking on the residents was to ensure care was provided. The DON stated that when he entered the room he checked for trip hazards, if fall interventions were in place, if the resident appeared clean and groomed, that personal items (and call light) was in reach, and if the resident received oxygen or used a catheter, that tubing was appropriately in place, clean, and dated if applicable. The DON stated that orders should be in place to manage and care for Resident #1's external catheter system. The DON said that he was sure it was care planned but was not familiar with the frequency of use or management of the external catheter collection. The DON indicated that (Resident #1) would be at risk to develop a UTI related to the external catheter if not changed or managed appropriately. The DON stated that staff should follow the manufacturer's instructions if unfamiliar with any appliance or assistive device. The DON stated the Hydrocolloid Paste that was scheduled for thirty days was discontinued on 05/22/24 because there was an order to apply zinc oxide skin barrier cream and the Hydrocolloid Paste had zinc oxide in the active ingredients. The DON did not indicate if there was a difference of the Hydrocolloid Paste to help maintain a wound healing environment and a zinc oxide skin barrier cream.<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 | The facility did not provide a policy and procedure on physician orders, infection prevention and to reduce irritation related to Catheter Care (indwelling, external) upon request on 06/08/24 during entrance conference or on 06/10/24 prior to and during the exit conference at 1:00 PM.<br><br>Record review of the facility's policy titled Resident Rights - Quality of Life revised 08/2020, revealed the following: Facility Staff provides care and services that ensure that resident's abilities in activities of daily living, including: hygiene, elimination, . and other methods of communication do not dimmish while in the care of the Facility; Demeaning practices and standards of care that compromise dignity are prohibited. Facility Staff will promote dignity and assist resident as needed by: A. Helping the resident to keep urinary catheter bags covered; B. Promptly responding to the resident's request for toileting assistance; and .; Facility Staff treats cognitively impaired residents with dignity and sensitivity. When caring for these residents, Facility Staff will address the underlying motives or root causes for behavior, and will not challenge or contradict the resident's beliefs or statements. |