STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676407	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Purehealth Transitional Care at Thr Arlington	800 W. Randol Mill Road, 6th Floor Arlington, TX 76012

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 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure the services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality for one of six residents (Resident #1) reviewed for post-surgical care. RN A and LVN C failed to obtain doctor's order for Resident #1 who was admitted with a tube connected to her stomach to drain an abscess on [DATE]. Resident #1's post-surgical site, stomach drain tube, and output were not documented from admission [DATE] through [DATE] when Resident #1 required hospitalization due to infection. RN A and LVN C were not trained on how to manage a drain. RN A and LVN C did not know why they did not obtain an order for the drain. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 12:00 pm. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm that is not Immediate Jeopardy with a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure has the potential to place all residents with surgical drain tubes for increased pain and risk of infection. Findings included: Review of Resident #1's face sheet on [DATE], reflected an [AGE] year-old woman admitted to the facility on [DATE]. Her initial admitted to the facility was [DATE]. Her diagnoses included encephalopathy (a condition of the brain that alters brain function or structure), acute duodenal ulcer with perforation (a condition in which an ulcer has burned through the stomach wall in a segment of the intestine tract allowing gastric content to leak into the abdominal cavity) , diverticulosis of the large intestine without perforation or abscess and without bleeding (this is a condition in which small bulging pouches develop in the large intestine), kidney stones, generalized muscle weakness, elevated white blood count, irregular heart rhythm (atrial fibrillation), and need for assistance with personal care. Resident #1 was a full code directive requiring CPR if her heart stopped. Review of Resident #1's order summary from [DATE] to [DATE] reflected no evidence of stomach tube drain care and monitoring of output. Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 99, indicating severe cognitive impairment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Clinical admission assessment by RN A dated [DATE] did not reflect that Resident #1 had any type of drains or evidence of having drains on her body on the care profile for drain assessment. Record review of Resident #1 progress notes between [DATE] and [DATE] did not indicate drainage tube care by RN A, CNA B, LVN C or RN D. Record Review of Resident #1's care plan on [DATE] did not reflect Resident #1's stomach tube and drain were assessed. In an interview with Resident #1 and family on [DATE] at 11:44 AM, family stated that on [DATE] the facility physician came to see Resident #1 and he asked him about taking the drain out because it was not putting out anything, and that was the first time, he saw anyone look at the stomach drain tube. Family stated on [DATE] while CNA B was cleaning resident, he notified family of oozing from the dressing of the stomach drain. Family stated he went out of Resident #1's room to get her nurse. He stated nurse notified the ADON and she came to look at the stomach drain, then facility physician was notified, and Resident #1 was sent to the ER. In an interview with LVN G on [DATE] at 12:24 PM, She sated she had worked with Resident #1 during the evening shift. She stated she assessed the dressing during her shift to make sure it was not soiled. LVN G stated she noticed that the drain bag had nothing in it to empty but she could not remember if Resident #1 had orders to care for her drain tube. She said she received no training by the facility prior to being assigned to take care of Resident #1's stomach drain tube. She said however she had seen one before and was familiar with how to open and empty the drain bag. She stated it had been a while since she had seen a drain like the one Resident #1 had. LVN G stated the risk to Resident #1was infection for not knowing orders to care for her drain tube. In a phone interview with RN A on [DATE] at 7:52 PM, she stated she had been employed by the facility for four months. She stated this was her first nursing job since completing her nursing exam. She stated she admitted Resident #1 to the facility and completed Resident #1's admission on [DATE]. She stated she documented the stomach drain tube in the progress note but she did not touch the drain tube. RN A stated she looked at the dressing and the bag attached to the drain tube. RN A said that she does not know why she did not obtain orders for drainage tube care from the physician. She stated she had not seen the type of tube drain that Resident #1 was admitted with. RN A stated she had not been trained by the facility to manage Resident #1's drain prior to being assigned to care for her. She stated the risk was infection for not knowing how to care for Resident #1's drain. In an interview with CNA B on [DATE] at 1:30 PM, he stated that he had been assigned Resident #1's hallway and as he was giving her incontinent care, he noticed that Resident #1's dressing was leaking. He stated that he was aware that Resident #1 had come to the facility after a surgical procedure but as a CNA, he was not allowed to access the drain or empty the drainage bag. He stated that he notified family because family was in the room and that family was very involved with resident's care. CNA B stated that family went out of the room and called RN D to the bedside. He stated he had not been trained on Resident #1's drain tube. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with LVN C on [DATE] at 5:30 PM, she stated she had been employed at the facility for 2 years. She stated when Resident #1 was moved from RN A's hallway, she took care of Resident #1 the next day [DATE]. LVN C stated the family informed her of the drain and she assessed it by looking at the skin around the dressing and she did not see anything unusual about her skin or drain. She stated she did not remove Resident #1's dressing to inspect the site. She said she had seen a drain tube like Resident #1's, but it had been a while. LVN C stated not getting orders or caring for Resident #1's drain tube was a risk for infection. In an interview with ADON on [DATE] at 03:11 PM, she stated that the admission process was to get report from the hospital, then if resident did not have orders when they came to the facility, to notify the physician, her, and the DON. She stated she was not notified of Resident #1's drain tube until [DATE] when she made rounds with the facility physician, and he accessed the drain. ADON stated that she in serviced RN D when she came to notify her that she had not seen a drain like Resident #1's before. ADON stated she showed her how to open it and made sure that it was compressed after emptying the drainage bag. ADON stated it was the responsibility of nurses to ask questions if they did not know how to do something. She stated nurses could also ask another nurse or ask the DON for one-on-one training on procedures they were unfamiliar on. She stated orders drive care and not having orders placed Resident #1 at risk of not getting drain care and infection. ADON did not know why RN A did not obtain orders for Resident #1. In a phone interview with RN D on [DATE] at 2:04 PM, she stated she had been employed to the facility for five months. She stated she was a new nurse and she had not seen a drain like Resident #1's drain tube. She stated she had no prior training from the facility to care for Resident #1's drain tube. RN D stated that she knew how to perform a dressing change and when CNA B notified her of the leak coming from under the drain tube dressing, she removed soiled dressing, cleaned the site with new gauze and notified the wound care nurse who came and assessed Resident #1's surgical site. She had not done a dressing change on Resident #1's drain site until the leaking was noticed [[DATE]]. She stated she also notified the ADON that she did not know how to manage Resident #1's drain tube and ADON did a one-on-one training at the bedside on [DATE]. RN D stated when the soiled dressing was removed the incision site was red, and purulence (pus/milky looking liquid substance) was noticed, and skin was warm. She stated facility physician was notified and Resident #1 was taken to the ER. She stated the risk to Resident #1 not getting orders to care for her surgical site with drain was infection. Wound care nurse could not be interviewed due to being terminated from facility. Interview with DON on [DATE] at 08:24 AM, she stated the facility had dropped the ball on Resident #1's lack of care orders for her drain. She stated the wound care nurse was expected to follow up and do a skin assessment on all new residents. It was an expectation that the wound care nurse should have gone to see Resident #1 to document the type of drain she had. She stated missing such things was one of the reasons wound care nurse was terminated. He failed to report issues to her. She stated an IDT meeting was held on [DATE] to identify where they went wrong. She stated they started a plan of correction and an in service on drain tube had already been started on [DATE] by the ADON. She stated she expected nurses to ask questions in they were unfamiliar with a procedure. She stated the risk to Resident #1 not getting orders to care for her drain was infection. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the Administrator on [DATE] at 05:05 PM, he stated all residents that are admitted to the facility are considered complex residents. He stated he expected nursing staff to communicate effectively and to obtain orders from physician as needed. He stated the expectation was that the admitting nurse would complete an initial skin assessment and then wound care nurse would follow up and complete a skin assessment on all new admissions within 48 hours unless the admission was on the weekend. The administrator did not state the risk to Resident #1. The administrator stated wound care nurse was terminated due to failure to report and other issues such as the incident with Resident #1. Review of completed competencies training for LVN G, LVN C, RN A, RN D, and CNA B did not reflected any competences relevant to caring for a resident with a drain. No training was reflected prior to caring for Resident #1. Review of facility policy titled Competency of Nursing Staff revision date [DATE] reflected, . The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care .Providing care includes but is not limited to assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs read in part . #6. Facility and resident-specific competency evaluations will include: Lecture with return demonstration for physical activities; A pre-and post-test for documentation issues; Demonstrated ability to use tools, devices, or equipment used to care for residents; Reviewing adverse events that occurred as an indication of gaps in competency; or Demonstrated ability to perform activities that are within the scope of practice an individual is licensed or certified to perform . On [DATE] at 12:00 PM the Administrator, the DON, and the nurse manager were informed of an Immediate Jeopardy existed and a copy of the IJ template was provided. Plan of Removal was accepted on [DATE] at 4:13 PM. Plan of Removal: [facility name] Date: [DATE] Ref: F726- Competent Nursing Staff Failure: To ensure nursing staff are trained relating to residents being admitted to the facility with catheters and tubes that require nursing care and preventing infection/hospitalization . On [DATE] DON, ADON, Medical Records Nurse, and Wound Care Nurse in-serviced licensed staff on identifying new patient treatment requirements based on their medical diagnoses and conditions. The training consisted specifically of ensuring physician orders are in place for catheters and tubes that are inserted into the body - both for a treatment and for specific drainage instructions. This in-service also included recognizing symptoms of infection or change of condition(s) that might lead to infection. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], the DON and ADON reviewed all patients for the presence of drains and found no other patients with a drain currently resides in the facility. Assessments consisted of a head-to-toe physical assessment to look for the presence of an inserted drain and visible signs or symptoms of infection. Vital signs were reviewed for changes that might indicate infection. No patients were noted to have any sign or symptom of a new infection. In addition, the medical charts of all patients were reviewed by comparing hospital discharge orders with facility admission orders and no missing treatment orders were found. If a patient had been noted with any missing treatment orders, including drain orders, the MD or NP would have been notified. If neither were available, or in an emergent situation, the DON or designee would have contacted emergency services (911). On [DATE] Chief Clinical Officer [name], in-serviced Director of Nursing for [facility name and location] on the following. 2. Competent Nursing Staff a. Ensuring treatment orders are in place for all drains, tubes, and catheters. b. Ensuring treatment orders are in place for the site of any inserted drain. c. Ensuring staff are trained in recognizing signs and symptoms of infection. d. Ensuring an effective head to toe body assessment is completed upon admission and within 48 hours. e. Ensuring clinical staff are knowledgeable in recognizing when an MD order is missing or ineffective, and how to contact the attending or surgeon for new orders. f. Ensuring a thorough clinical review/compare of the hospital discharge orders and facility admission orders occurs with each admission. g. Ensuring a monitoring log is created with the admission criteria, treatment criteria and head to toe assessment criteria. The DON will be responsible for maintaining the log 5 times per week at a minimum for 12 weeks. On [DATE] initiated staff (LVN, RN, CNA) in-servicing on competent nursing with a completion date of [DATE] at 5pm. Any staff who have not received in-serving by [DATE] at 5pm will not be permitted to work until in-servicing has been completed. Measures to be put into practice to monitor to prevent future occurrence will include: a. Medical records/Designee will cross check progress notes/clinical admission assessments for drain orders. b. Wound Care nurse will perform head to toe assessment on all new admissions within 48hrs ensuring appropriate treatments are obtained. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. Interdisciplinary Team will audit resident orders 5x weekly times 12 weeks to ensure appropriate drain orders are entered. Any findings will be immediately corrected with further education and/or disciplinary action. During monitoring, interviews were conducted on [DATE] from 12:01 pm through 5:53 pm. The facility nursing staff revealed they had been trained on what to do when they received a resident without orders, a resident with any type of drains/ lines/tubes, head to toe assessment, reporting to the physician, reporting to ADON, DON, and administrator, and CNAs reporting to the nurses. The staff interviewed consisted of RN A, CNA B, LVN C, RN D, RN F, nurse manager, ADON, and new wound care nurse. During interview and observation on [DATE] from 02:00pm to 4:00 pm, five residents (Resident #1, #2, #3, #4, #5) had some form of line, tube or drain coming out of their bodies. Resident #2 had a PICC line, Resident #3 and Resident #4 had an indwelling catheter to drain urine from the bladder and Resident #5 had a JP drain. All drains/lines were dated, emptied and clean, output documented. Residents stated that they had no concerns with their lines. They stated their lines/drains/tubes were emptied as needed, cleaned and new dressing applied as needed. Two residents with indwelling catheters stated that they received catheter care daily. All residents stated output had been measured, and emptied by the nurses and that site care and assessment was done every shift. Record review of orders for the five residents on [DATE], reflected line/drain/tube care, management, and date to change/replace. Record review of MAR/TAR for the five residents on [DATE], reflected dated inserted, dressing change dates, amount of output. Record review of orders for the five residents [DATE], reflected line/drain/tube care, management, and date to change/replace. Record review of MAR/TAR for the five residents on [DATE], reflected dated inserted, dressing change dates, amount of output. Record review of in service dated [DATE] titled Competent nursing/ infection control in connection IJ726, reflected RNs, LVNs, MDS, ADON, and CNAs had received one on one training by DON and Infection control nurse on [DATE]. Nursing department staff were trained regarding the following topics: Skin assessments - weekly head to toe assessments, identify areas, who to notify, what/where to document. Changes of condition - who to report to, things to mention, who to notify, how to document. Wounds - notify physician, obtain orders, and document. Resident care - signs and symptoms and prognosis Documentation on electronic healthcare system. CNAs to report any skin issues, bleeding, drain/line issues during incontinence care and showers. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the Administrator on [DATE] at 05:53 PM, he sated one on one in services had been completed with nursing staff and some of the in services had been completed over the phone. He stated all nursing staff would not be allowed to work their shift until they were in-served on Competent nursing and infection control. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm that is not Immediate Jeopardy with a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of six residents reviewed for quality of care. The facility failed to ensure Resident #1's stomach drain tube and drainage bag were documented on admission to the facility on [DATE] and accurately assessed, monitored, and treated. The drain was identified on [DATE] when family mentioned the stomach tube drainage to the physician and four days later on [DATE], Resident #1 required hospitalization due to infection. The facility failed to ensure the surgeon was notified for Resident #1's missing orders for drain tube monitoring. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 12:00 pm. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm that is not Immediate Jeopardy with a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk for a delay in treatment or diagnosis of new symptoms, a decline in the resident's condition, the need for hospitalization or death. Findings included: Review of Resident #1's face sheet on [DATE], reflected an [AGE] year-old woman admitted to the facility on [DATE]. Her initial admitted to the facility was [DATE]. Her diagnoses included encephalopathy (a condition of the brain that alters brain function or structure), acute duodenal ulcer with perforation (a condition in which an ulcer has burned through the stomach wall in a segment of the intestine tract allowing gastric content to leak into the abdominal cavity) , diverticulosis of the large intestine without perforation or abscess and without bleeding (this is a condition in which small bulging pouches develop in the large intestine), kidney stones, generalized muscle weakness, elevated white blood count, irregular heart rhythm (atrial fibrillation), and need for assistance with personal care. Resident #1 was a full code directive requiring CPR if her heart stopped. Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 99, indicating severe cognitive impairment. MDS did not reflect any evidence of Resident #1's stomach tube or drainage bag. Review of Resident #1's order summary from [DATE] to [DATE] reflected Amoxicillin oral tablet 200 mg, give 1 tablet by mouth every 12 hours for infection for 1 day . Order date [DATE]. Acetaminophen tablet 500 MG, give 1 tablet by mouth every 6 hours as needed for pain start date [DATE]. Acetaminophen increased to 1000 MG on [DATE]. Acetaminophen tablet 500 MG, give 2 tablets by mouth every 6 hours as needed for pain start date [DATE]. The acetaminophen medication did not specify if it was related to drain/abdomen. Order summary did not reflect any evidence of orders for Resident #1's stomach tube or drain bag. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's care plan on [DATE], reflected Resident #1's stomach tube and drain were not addressed. Review of Resident #1's Medication/Treatment Administration Record (MAR/TAR), dated [DATE] to [DATE], reflected no evidence of orders for wound care to Resident #1's drainage tube or of any incision care treatment. Skin was noted by RN A as WNL signed off on every shift from [DATE] to [DATE] , however there was no documentation of site care, dressing change, temperature to site, drainage amount and if so, how much was noted. PRN Acetaminophen 500 mg, 2 tablets by mouth as needed for pain was administered on [DATE] in the morning, one time for pain of 4 out of 10. On [DATE] it was administered two times, for morning pain of 5 out of 10, and afternoon pain of 4 out of 10. On [DATE] it was administered three times for morning pain of 5 out of 10, afternoon pain of 4 out of 10, and evening pain of 4 out of 10. Facility did not provide MAR for [DATE] to [DATE]. Review of Resident #1's Clinical admission assessment by RN A dated [DATE] did not reflect that Resident #1 had any type of drains or evidence of having drains on her body on the care profile for drain assessment. Review of Resident #1's hospital discharge records dated [DATE] at 2:24 pm, reflected continuation of medications acetaminophen 500 mg tablet (for pain not specific), alum-mag hydroxide-simeth [DATE] mg/5 ml suspension (gas relief medication), artificial tears drop (for dry eyes), fluconazole 150 mg tablet, heparin 5, 000 units/ml solution (blood thinner), labetalol 5 mg/ml solution (for blood pressure medication), melatonin 3 mg tablet (sleep aide), metoprolol tartrate 50 mg tablet(for blood pressure medication),, pantoprazole 40 mg tablet (for reflux/heart burn) and Amoxicillin oral tablet 200 mg every 12 hours for infection for 1 day . The discharge record reflected to schedule an appointment with family practice as soon as possible post hospital discharge follow up appointment. No orders for the drainage tube were noted. Review of Resident #1's progress notes by RN A dated [DATE] at 07:30 AM, revealed Resident #1 skin assessment as follows: incision at the RUQ with a draining tube, the dressing is clean dry and intact, PICC line on the arm was taken off on ,d+[DATE] dressing upper arm. Oxygen is nasal canula 2L, LBM today [DATE]. No progress notes related to drainage tube were recorded during skin checks, incontinent care, or shower/bed bath between [DATE] to [DATE] at 4:20 pm. Review of Resident #1's progress notes by RN D dated [DATE] at 06:31 PM, reflected a change in condition for uncontrolled pain. An assessment of the abdomen revealed abdominal pain. Primary care provider recommendation was to send Resident #1 to the emergency room . Progress notes on [DATE] at 06:31 pm was the first progress note to mention anything related to the drainage tube. Review of Resident #1's progress notes by RN D dated [DATE] at 7:01 PM, reflected as follows Patient [Resident #1] had a change in condition. Purulent (pus/milky looking liquid substance) discharge observed from surgical drain site. Drainage bag doesn't seem to be working, right, and no drainage has been noted since patient's admission into facility. Surgical site warm to touch. Wound nurse examined surgical site, took pictures, and changed dressing. [physician] notified and pictures shared with him. [physician] requests to send patient downstairs to ER for eval[evaluation]. Required documentation prepared. ER nurse is called and notified of patient's condition. Patient is assigned to Room [#] in ER. Vitals taken and within normal range, BP ,d+[DATE], Temp 98.8, HR 67 and RR 20. Patient's [family] present. Patient is taken downstairs accompanied by [family]. Nurse [name] receives patient and receives report from me. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's hospital record dated [DATE] through [DATE], reflected the following summary: Resident #1 was evaluated by a surgeon and an Infectious Diseases doctor, and they noted diagnosis as Post operation infection of the intra-abdominal abscess IR drain. Resident #1 presented to ER from facility with purulent discharge from the IR drain. Surgeon replaced the infected IR drain and a new drain was placed. Resident #1 still complained of abdominal pain then a KUB was done which showed possible retraction of drain. The CT revealed that the drain had migrated. Resident #1's drain was repositioned. Cultures showed Klebsiella (a bacteria that is mostly spread from person to person via contact. The bacteria spreads by contamination in the environment, and it is the most common health care associated infection). Resident was started on intravenous antibiotics Zosyn and Diflucan and then she was e started cefepime flagyl and fluconazole as per Infectious Diseases doctor recommendations. It was recommended that the drain was flushed with saline 10 cc every 12 hours and that a repeat CT scan would to be done again in , d+[DATE] weeks . Resident #1 was discharged back to the facility in stable condition on [DATE] and a recommended order to follow up with the surgeon. In an interview with Resident #1 and family on [DATE] at 11:44 AM, family stated that he was frustrated with the first surgeon because Resident #1 was admitted to facility on [DATE] without him getting any discharge paperwork from the hospital. He stated that the ADON obtained it for him later. Family stated that he mentioned the drain to the facility physician on [DATE] stating that the drain was not putting out any drainage. Family stated that the facility physician told him that he would contact the surgeon. Family stated that the facility physician did not even look at the drain. He stated that he did not see any nurses observed drain site or check the drain while he was in the facility. Family stated that on [DATE] the facility physician came to see Resident #1 and he asked him about the drain not putting out anything and what the surgeon had said to do next. Family stated that the facility physician stated that he had left a voicemail for the surgeon, and he had not heard from him. On [DATE] as CNA B was cleaning resident, he notified family that he noticed oozing from the dressing of the drain. Nurse was notified, then ADON came to see resident and facility physician was notified and Resident #1 was sent to the ER. In a phone interview with RN A on [DATE] at 7:52 PM, she stated that she admitted Resident #1 to the facility and completed Resident #1's admission on [DATE]. She stated that she did not ask about the drain during report because she assumed that Resident #1 already had an order since she was transferring from the hospital attached to the facility. She stated that RN F on day shift had gotten report from the hospital. RN A stated it was her responsibility to notify the facility physician to obtain orders or called the hospital nurse that gave them report for clarification on monitoring Resident #1's drain. She stated the facility process was to notify the facility physician or on call physician if they had an admission without orders. She stated that she did not follow up to see if orders had been obtained for Resident #1 the next day [DATE] because Resident #1 had been moved from her assignment due to relocation to another room. She sated the risk was infection for not knowing how to care for Resident #1's drain. She stated that it was neglect that she did not obtain orders to care for Resident #1. (continued on next page)

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	676407	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Purehealth Transitional Care at Thr Arlington	800 W. Randol Mill Road, 6th Floor Arlington, TX 76012

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA B on [DATE] at 1:30 PM, he stated that he had been assigned Resident #1's hallway and as he was giving her incontinent care on [DATE] he noticed that Resident #1's dressing was leaking . He stated that he was aware that Resident #1 had come to facility after a surgical procedure but as a CNA, he was not allowed to access the drain or empty the drainage bag. He stated that he notified family because family was in the room and that family was very involved with resident. CNA B stated that family went out of the room and called RN D to the bedside. He stated neglect was not going to a resident's room when they called, not cleaning a resident when they are soiled and not reporting to the nurse if a resident needs something. In an interview with LVN C on [DATE] at 5:30 PM, she stated when Resident #1 was moved from RN A's hallway, she took over care for Resident #1 the next day [DATE]. LVN C stated the family informed her of the drain and she assessed it. She stated Resident #1's skin around the dressing was intact and she did not see anything unusual about her skin or drain. She stated she knew Resident #1 did not have orders for drain care and management. She stated all she did was assessed the skin around the dressing. She stated that she could have reached out to the physician for orders. She stated the risk to Resident #1 was neglect for not having orders to care for her drain. In an interview with RN F on [DATE] at 4:15 PM, she stated she got report from the hospital for Resident #1 and she gave the report to RN A. She stated she did not admit Resident #1. She stated neglect was not addressing a resident's need, not taking care of them as you should. In an interview with ADON on [DATE] at 03:11 PM, she stated RN A should have gotten an order set for drain care. She stated that the process was to get report from the hospital, then if resident did not have orders, to notify the physician, her, the wound nurse, and the DON. She stated she was not notified of Resident #1's drain until [DATE] when she made rounds with the facility physician, and he assessed the drain. She stated the physician should have put orders to maintain the drain. ADON stated on [DATE], RN E notified her of Resident #1's drain leaking. She stated upon assessment it was warm to touch and that she worked closely with Resident #1's family to send Resident #1 to the ER after communicating with the facility physician. She stated orders drive care and not having orders placed Resident #1 at risk of not getting drain care and infection. She stated that she started to in-service nurses on drain management and infection control after incident with Resident #1 on [DATE]. She stated she did not like the word neglect, but she could see how not obtaining orders can be considered neglectful. Attempts to interview surgeon and or nurse practitioner was unsuccessful on [DATE] at 2:33PM. In an interview with DON on [DATE] at 4:52 PM, she stated that if there are no orders at admission to the facility, she expected nurses to reach out to the physician. She stated the wound care nurse should have seen Resident #1 as she was a new admission to determine the type of drain that Resident #1 had and to request additional care orders. She stated all findings during assessment should be documented in resident's care clinical documentation. DON stated that the wound care nurse at the time of Resident #1's admission [[DATE]], was no longer with the facility because he missed a lot of important details such as for Resident #1's drain. She stated that orders drive care and Resident #1 was placed at a risk for not getting drain management, which caused drain issues and possible infection. She stated the ADON started an in-service for nursing staff the same day Resident #1 was sent to hospital on [[DATE]]. DON said she could not say if not obtaining drain care orders for Resident #1 was neglect. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the administrator on [DATE] at 05:05 PM, he stated all residents that are admitted to the facility are considered complex residents. He stated he expected nursing staff to communicate effectively and to obtain orders from the physician as needed. He stated the expectation was that the admitting nurse would complete an initial skin assessment and then wound care nurse would follow up and complete a skin assessment on all new admissions within 48 hours unless the admission was on the weekend. The administrator did not state the risk to Resident #1. He stated the facility admitted 60 to 80 residents each month and he did not know each one's care. The administrator stated wound care nurse was terminated due to failure to report and other issues. Review of facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention program, revision date [DATE], reflected, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms . Interview with DON on [DATE] at 08:24 AM, she stated the facility had dropped the ball on Resident #1's lack of care orders for her drain. She stated an IDT meeting was held on [DATE] to identify where they went wrong. She stated they started a plan of correction. On [DATE] at 12:00 PM the Administrator, the DON, and the nurse manager were informed of an Immediate Jeopardy existed and a copy of the IJ template was provided. In an interview with the facility physician on [DATE] at 01:52 PM, he stated that he was aware that Resident #1 had a drain. He stated that it was the surgeon's responsibility to place care orders for the drain. He said usually all surgical admissions with any drains, lines or tubes had orders from the surgeon. He stated that Resident #1's family asked him to remove the drain because there was no output. The facility physician stated that it was common sense and a nurse best practice to clean the skin around the incision, to monitor output and to report change. He stated it was common sense for nurses to reach out to surgeons for orders so that they can know what to monitor, fluid amount for output and any interventions needed. He stated there was a risk for infection if not monitored. In a phone interview with RN D on [DATE] at 2:04 PM, she stated that she had been employed at the facility for five months. She stated she cleaned around the insertion site, and she changed the dressing because it was soiled after CNA B notified her of the leak. She stated she notified the wound care nurse who came and took pictures and sent to the physician. She stated Resident #1 was neglected because no one got orders to care for her drain. She stated the risk for not providing care to the surgical site was infection. She stated neglect was not providing care that is required to Resident #1. Plan of Removal was accepted on [DATE] at 4:13 PM. Plan of Removal: [facility name] Date: [DATE] Ref: F600- Abuse and Neglect Failure: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	To prevent future occurrences of potential negligence by ensuring licensed staff identify, monitor, assess, and report issues relating to residents being admitted to the facility with catheters and tubes that require nursing care to prevent infection/hospitalization . DON, ADON, Nurse manger, and new Wound care nurse received in-service training on [DATE] which consisted specifically of ensuring physician orders are in place for drains, tubes and catheters that are inserted into the body -for treatments and for specific drainage instructions. This in-service also included recognizing symptoms of infection or change of condition(s) that might lead to infection. On [DATE], the DON and ADON reviewed all patients to ensure that treatment orders specific to their medical condition(s) and diagnoses are in place. No omissions were found. If a patient had been noted with any missing treatment orders, including drain orders, the MD or NP would have been notified. If neither were available, or in an emergent situation, the DON or designee would have contacted emergency services (911). On [DATE] Chief Clinical Officer in-serviced Director of Nursing for [facility name] on the following. 1. Abuse/Neglect a. Ensuring treatment orders are in place for all drains, tubes and catheters b. Ensuring treatment orders are in place for the site of any inserted drain c. Ensuring staff are trained in recognizing signs and symptoms of infection d. Ensuring an effective head to toe body assessment is completed upon admission and within 48 hours e. Ensuring clinical staff are knowledgeable in recognizing when an MD order is missing or ineffective, and how to contact the attending or surgeon for new orders f. Ensuring a thorough clinical review/compare of the hospital discharge orders and facility admission orders occurs with each admission. g. Ensuring a monitoring log is created with the admission criteria, treatment criteria and head to toe assessment criteria. The DON will be responsible for maintaining the log 5 times per week at a minimum for 12 weeks. On [DATE] initiated staff (LVN, RN, CNA) in-servicing on neglect with a completion date of [DATE] at 5pm. Any staff who have not received in-serving by [DATE] at 5pm will not be permitted to work until in-servicing has been completed. Measures to be put into practice to monitor to prevent future occurrence will include: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. Medical records/Designee will cross check progress notes/clinical admission assessments for drain orders b. Wound Care nurse will perform head to toe assessment on all new admissions within 48hrs ensuring appropriate treatments are obtained. c. Interdisciplinary Team will audit resident orders 5x weekly times 12 weeks to ensure appropriate drain orders are entered. Any findings will be immediately corrected with further education and/or disciplinary action. During monitoring, interviews were conducted on [DATE] from 12:01 pm through 5:53 pm. The facility nursing staff revealed they had been trained on what to do when they received a resident without orders, a resident with any type of drains/ lines/tubes, head to toe assessment, reporting to the physician, reporting to ADON, DON, and administrator, and CNA's reporting to the nurses. The staff interviewed consisted of RN A, CNA B, LVN C, RN D, RN F, nurse manager, ADON, and new wound care nurse. During interview and observation on [DATE] from 02:00pm to 4:00 pm, five residents (Resident #1, #2, #3, #4, #5) had some form of line, tube or drain coming out of their bodies. Resident #2 had a PICC line, Resident #3 and Resident #4 had an indwelling catheter to drain urine from the bladder and Resident #5 had a JP drain. All drains/lines were dated, emptied and clean, output documented. Residents stated that they had no concerns with their lines. They stated their lines/drains/tubes were emptied as needed, cleaned and new dressing applied as needed. Two residents with indwelling catheters stated that they received catheter care daily. All residents stated output had been measured, and emptied by the nurses and that site care and assessment was done every shift. Record review of orders for the five residents on [DATE] , reflected line/drain/tube care, management, and date to change/replace. Record review of MAR/TAR for the five residents on [DATE] , reflected dated inserted, dressing change dates, amount of output. Record review of in service dated [DATE] titled Abuse/ in connection IJ 600, reflected RNs, LVNs, MDS, ADON, and CNAs had received one on one training by DON and Infection control nurse on [DATE]. Nursing department staff were trained regarding the following topics: Skin assessments - weekly head to toe assessments, identify areas, who to notify, what/where to document. Changes of condition - who to report to, things to mention, who to notify, how to document. Wounds - notify physician, obtain orders, and document. Resident care - signs and symptoms and prognosis Documentation on electronic healthcare system. CNAs to report any skin issues, bleeding, drain/line issues during incontinence care and showers. (continued on next page)

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