STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455333	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharpview Residence and Rehabilitation Center	7505 Bellerive Houston, TX 77036

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 32422 Based on observation, interview and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, for oxygen therapy for two of two residents (Resident # 29 and Resident #186) reviewed for respiratory care. -The facility failed to follow the physician orders for Resident #29's oxygen administration. -The facility failed to provide tracheal care and suctioning according to professional standards for Resident #186. These deficient practices could result in the resident's not receiving the care and services ordered by the physician and a decline in health status and oxygen deprivation. Findings included: Record review of Resident #29's facility admission record dated 06/11/2024 revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #29's medical diagnoses included Alzheimer's Disease, dementia, hyperosmolality (a serious complication of diabetes that causes very high blood sugar and dehydration), hypernatremia (high concentration of sodium in the blood), hypertension (high blood pressure), acute kidney failure, and dysphagia (difficulty swallowing). Record review of Resident #29's quarterly MDS assessment, dated 04/11/2024 revealed a BIMS (Brief Interview for Mental Status) was not completed due to the resident being rarely or never understood. Further review showed Resident #29 was receiving oxygen therapy at the facility. Record review of Resident #29's care plan last reviewed on 05/22/2024 revealed she was on supplemental oxygen for Respiratory Failure. Interventions included: administering oxygen per doctor's order, receiving monitoring for symptoms of respiratory distress and report to doctor as needed, and being provided extension tubing or portable oxygen apparatus as needed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #29's order summary report dated June 2024 revealed on 02/14/2023 she had an order to apply continuous O2 sat (saturation) at 2L (liters) per minute every shift for SOB (shortness of breath). On 12/01/2022 Resident #29 had an order to check O2 sat every shift and as needed. Further review revealed her oxygen saturations for June 2024 were within normal range. During an observation on 6/11/2024 at 9:33am, Resident #29's concentrator was set on 1.5L. Resident #29 was sleeping in bed and appeared comfortable and not in respiratory distress. During an observation on 6/11/2024 at 3:44pm, Resident #29's concentrator was set on 1.5L. Resident #29 was lying in bed and did not appear to be in respiratory distress. During an observation on 6/12/2024 at 10:02am, Resident #29's concentrator was set at 1.5L. She was sleeping in bed, no discomfort or respiratory distress was noted. Her humidifier was dated 06/12/2024. Resident #186 Record review of the facility admission record dated 6/14/2024 revealed an admitted [DATE]. Resident #186 was an [AGE] year-old male with diagnoses that included dysphagia (difficulty swallowing), tracheostomy status ((also called a tracheotomy) is a procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe (trachea) to help you breathe) and gastrostomy status (a surgical opening into the stomach for nutritional support or gastric decompression). Record review of Resident #186's care plan revealed a care plan to address Tracheostomy Status: Resident #186 has a tracheostomy r/t traumatic subdural hemorrhage with loss of consciousness: Resident # 186 will have no abnormal drainage around the trach site through the review date. 06/12/24 11:31 AM Resident #186 was at risk chronic pain r/t Wound at sacrum: Resident #186 will display a decrease in behaviors of inadequate pain control: irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, and groaning through the review date. Record review of Resident # 186's Admission MDS dated [DATE], revealed the BIM score was blank. Resident was documented to be total dependent for all ADL's. Record review of Resident #186's physician orders for June 2024 with a start date pf of 5/29/2024 revealed the following orders: -Change Shiley (Shiley inner cannulas that twist to lock in place are reusable) 6 disposable inner cannula at bedtime for Patent airway. -Change trach tie as needed. -Change trach tie at bedtime every Monday, Wednesday and Friday for maintenance and infection control. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident is on Enhanced Barrier Precautions regarding tracheostomy care/wound care: Use a gown and gloves for high-contact resident care. If there is a risk of splash or spray, use a face shield as needed. Every shift for prevention spread of infection. Don gloves and gown before high contact resident care. Remove gown and gloves and handwash/sanitize hands, before exiting the room and before providing care to another resident. -Trach care every 12 hours for maintenance/infection prevention. -Tracheal suction every 6 hours for Patent airway. -Clean the sacrum wound with normal saline, pat dry, and apply med honey and calcium alginate. Cover with 4 x 4 form dressing. Every day shift for wound with a start date of 6/2/2024. -Wash wound with NS, pat dry. Apply calcium alginate to wound bed, cover with dry dressing, one time a day for wound. Record review of Resident #186's care plan, no date provided revealed a care plan to address Tracheostomy Status: Resident #186 has a tracheostomy r/t traumatic subdural hemorrhage with loss of consciousness: Resident #186 will have no abnormal drainage around the trach site through the review date. 06/12/24 11:31 am Resident #186 is at risk chronic pain r/t Wound at sacrum: Resident #186 will display a decrease in behaviors of inadequate pain control: irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, and groaning through the review date. Record review of Resident #186's Treatment Administration Record for June 2024 revealed tracheal suction every 6 hours for patent airway was provided on 6/1/2024 through 6/13/2024. Observation on 6/11/2024 at 10:00 am, revealed Resident #186 lying in bed, trach in place, oxygen was in place, resident appeared to be asleep. Observation of Resident #186 on 6/12/2024 at 1:15 PM, resident was observed lying in bed with the head at a 30-degree angle. Resident #16's oxygen concentrator read 3.5L/min. Observation on 06/12/2024 at 1:26 PM revealed Resident #186 was in bed with audible moist breath sounds. Respiratory Therapy (RT) was at bedside observing tracheostomy care, LVN A stated resident was not usually this moist and they changed the resident's inner cannula every day. LVN A set up a clean field on the bedside table, checked oxygen saturation checked and it was 99%. She changed gloves without washing hands or using hand sanitizer, grabbed the sterile suction catheter kit tray, opened it, then doff gloves without washing hands, picked up the sterile gloves, don sterile gloves then picked up normal saline at Resident #186's bed side, poured it in the tray. LVN A picked up the suction tubing from the sterile suction kit connected it to the suction machine at Resident #186's bed side. LVN A then used the sterile gloved right hand to removed oxygen mask on Resident #186's trach, then inserted suction catheter into the tracheostomy tube x 2 times, then rinsed tubing with normal saline LVN A donned clean gloves, picked up Trach Care Kit without changing gloves. LVN A opened the sterile Trach Care Kit, using the same gloves picked up sterile 4x4 gauze, brush and sterile gloves placed on the bedside table. LVN A, using the same gloves, removed tracheostomy inner canula, then picked a syringe 10 ml normal saline (NS) covered with plastic wrap, LVN A unwrapped NS the rinsed tracheostomy inner cannula x 2 times, then re-inserted it to trach site. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/12/2024 at 1:54 PM, LVN A stated she did not wash her hands during trach care or do suctioning right. She stated she should have used sterile technique throughout, and she had last in-service on tracheostomy care in 1 month ago and not suctioning tracheostomy with cleaned technique could result infection or cardiac arrest. She stated she works with Resident #186 most of the time. In an interview with RT on 6/12/24 at 2:00 PM regarding tracheostomy care she observed LVN A performed , she said LVNA did not maintained sterile technique and she had in-services with LVN A about a month ago with return demonstration. RT said she was to retrain all the staff and she thought she was just nervous. In an interview on 06/12/2024 at 5:45 PM, when Surveyor described the observed trach care, suctioning for Resident #186, the DON stated tracheostomy care should be done using sterile procedure. The DON said the last in-services on tracheostomy was last month. The DON said LVN A always worked with Resident #186, and she was going to have more training with the nurses on tracheostomy care and not maintaining sterile technique could result in respiratory tract infection. During an interview on 6/12/2024 at 10:02am with RN A, she stated that Resident #29 was her resident, and that Resident #29 gets continuous oxygen. RN A said she checks Resident #29's oxygen every hour and checks the humidifier daily. RN A said that in the last few days she noticed Resident #29's concentrator dipping after she sets it to 2L per physician order, but she has not told the DON yet. She said Resident #29's oxygen saturation levels have been normal in the last few days. RN A said that she reads the oxygen level by looking down at the machine from a standing position, not sitting directly in front of the machine. RN A had in-services the previous week on how to care for residents on oxygen therapy. Interview with the DON on 6/12/2024 at 2:25pm, she said none of her nurses have told her about oxygen concentrator issues, but that she would look into it. The DON said her expectations for her nurses are that they follow procedures correctly. If residents do not get the right amount of oxygen therapy as prescribed by their physicians, it could cause them distress and they would not be able to breathe properly. She said her staff had an in-service on oxygen and respiratory therapy the previous week and that she will do an in-service on how to accurately read the oxygen concentrator immediately. Record review of the facility policy entitled Oxygen Administration dated copyright 2022, read in part, Oxygen is administered under orders of a physician .The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as when to administer such as continuous or intermittent .equipment setting for the prescribed flow rates. Record review of the facility policy and procedure entitled Tracheostomy Care dated copyright 2021, read in part . Policy: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy and procedure entitled Tracheostomy Care-Suctioning, dated , read in part . Policy: The facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block the airway.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 9% based on 3 errors out of 32 opportunities, which involved 3 of 9 residents (Resident #29, Resident #14 and Resident #6) reviewed for medication errors. 1. RN A did not administer Sodium Chloride (a prescription medicine used to replenish lost water and salt in your body due to certain conditions like low salt syndrome) to Resident #29 as ordered by the physician. 2. MA A did not administer Losartan Potassium (a drug used to lower blood pressure) to Resident #14 as ordered by the Physician. 3. RN B did not administer Valproic Acid (a drug works by lowering seizures) to Resident #6 as ordered by the physician. These failures could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications. Findings included: Record review of Resident #29's face sheet revealed a female admitted on [DATE]. Her diagnoses sodium deficiency displacement of other gastrointestinal prosthetic devices (tube surgically inserted in stomach used to feeding and medication administration), implants and grafts, Alzheimer's disease(a brain disorder that slowly destroys memory and thinking skills, eventually affecting a person's ability to perform simple tasks), cerebral infarction (death of brain tissue due to a lack of blood flow to the brain), acute respiratory failure with hypoxia (lack of oxygen to the brain). Record review of Resident #29's quarterly MDS assessment dated [DATE] revealed a BIMS score of blank out of 15 which indicated severely cognitive impairment. She needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #29's Physician Order Report for 08/28/2023 revealed an order for Sodium Chloride oral tablet Give 1 gram via peg-tube two times a day. Record review of Resident #29's MAR revealed Sodium Chloride oral tablet Give 1 gram via peg-tube two times a day. Scheduled time was for 9:00 AM and 5:00 PM In an observation and interview on 6/11/24 at 8:55 PM RN A prepared and administered Sodium Chloride 500 mg 1 tablet from the bottle. RN A then crushed Sodium Chloride 1 tablet and dilute in water and administered with other medication via GT . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/13/24 at 10:00 Am with RN regarding not giving Sodium Chloride as ordered by the doctor, she said she did not check the order well and she should have given 2 tablets. She said she had in-services on medication administration, and she had been working on and off for the facility for 7 years. She knew not giving the medication correctly could result in having medication error and the medication would not be effective. 2. Rrecord review of resident #14's face sheet revealed a female admitted on [DATE]. her diagnoses type 2 diabetes mellitus (high blood glucose) with diabetic neuropathy (nerve problem), chronic kidney disease, stage 3 morbid (severe) obesity due to excess calories (excess fat due too much food consumption), anemia in other chronic diseases classified elsewhere, bipolar disorder (abnormal mood swing), essential (primary) hypertension (high blood pressure). Record review of Resident #14's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated no cognitive impairment. She needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #14's Physician Order Report for 01/12/2024 revealed an order for Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 1 tablet by mouth one time a day for Hypertension Hold for SBP< 110, DBP< 60, HR <60. Observation on 6/12/24 at 8:05 AM, MA A did not administered Losartan Potassium Oral Tablet 25 MG with other medications she administered to Resident #14. MA A initialed Losartan Potassium Oral Tablet 25 MG with other medications given at 8:00 AM In a telephone interview on 6/13/24 at 2:30 PM, MA A said was off duty and thought she did administer all medication to Resident #14, she said she got was in-serviceds on medication. 3. Record review of Resident #6's face sheet revealed a female admitted on [DATE]. Her diagnoses type 2 diabetes mellitus (high blood glucose) gastrostomy infection, epilepsy (seizure), without type 2 diabetes mellitus with diabetic neuropathy (nerve pain), unspecified status epilepticus, aphasia (unable to talk), severe intellectual disabilities, chronic kidney disease, dysphagia(difficulty swallowing) Record review of Resident #6's quarterly MDS assessment dated [DATE] revealed a BIMS score was blank out of 15 which indicated severely cognitive impairment. She needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #6s Physician Order Report for 03/07/2024 revealed an order for 3/7/24 Valproic Acid Oral Solution 250 MG/5ML (Valproate Sodium) Give 10 ml via G-Tube every 12 hours for Seizure. Observation on 6/12/24 at 8:18 AM, RN B poured Valproic Acid Oral Solution 250 MG/5ML 12 ml in a medication cup and others medication via G-Tube. In an interview with RN B on 6/13/24 at 10:00 AM, regarding not administering Valproic Acid Oral Solution 250 MG/5ML 10 mls as ordered by the physician's she said would be more careful . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/13/24 at 12:38 PM the DON said the staff should read the MAR and blister packet before medication administration to Residents. She said she expected nursing staff to ensure the medication order and inventory matched because the correct dosage needed to be provided to the resident. In an interview on 6/13/24 at 12:46 PM the Administrator said he expected nursing staff to follow the physician orders. Record review of facility's policy on Medication Administration undated: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state , as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview and record review the facility failed to obtain laboratory services to meet the needs of its residents for 1 of 5 residents (Resident #29) reviewed for laboratory services. The facility did not obtain CBC levels for Resident #29 following orders on 6/6/2024. This failure could place residents at risk of not receiving treatment and services to meet their needs. Findings included: Record review of Resident #29's facesheet dated 06/11/2024 revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #29's medical diagnoses included Alzheimer's Disease, dementia, hyperosmolality (a serious complication of diabetes that causes very high blood sugar and dehydration), hypernatremia (high concentration of sodium in the blood), hypertension (high blood pressure), acute kidney failure, and dysphagia (difficulty swallowing). Record review of Resident #29's quarterly MDS assessment, dated 04/11/2024 revealed a BIMS (a brief interview to gauge a resident's cognitive intactness) was not completed due to the resident being rarely or never understood. Record review of Resident #29's doctor visit summary dated 04/17/2024 revealed she was in a vegetative state. Record review of Resident #29's medical chart, her last CBC labs with differential (a lab that counts a person's different types of cells to give their healthcare providers a picture of their overall health) was on 02/08/2024, 01/25/2024, and 10/12/2023. Record review of Resident #29's MAR and TAR for June 2024 captured 06/11/2024 at 3:05pm, resident had a Lipid (fat) panel including CBC scheduled for 06/06/2024, which read, one time only for lab until 06/07/2024. The order for 6/7/2024 was initialed by RN B. The MAR and TAR further stated Resident #29 was receiving Eliquis Tablet 2.5 MG (medication given to prevent blood clots) via G-tube (a tube connected to a person's stomach through which medicine, nutrition and hydration can be given. She was also scheduled for anticoagulant monitoring via low platelet count. During an observation on 6/11/2024 at 3:44pm, Resident #29 was lying in bed and did not appear to be in respiratory distress. Resident #29 did not respond to questions. During an observation on 6/12/2024 at 10:02am, Resident #29 was sleeping in bed, no discomfort. Interview with on 6/14/2024 at 11:00am with RN B, she stated that Resident #29 was her resident. Resident #29 had a CBC test scheduled for 6/24/2024 in her orders but RN B was unaware of the test ordered on 6/6/2024. She said she did not remember the earlier order dated 6/6/2024 nor signing for that order on 6/6/2024. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 6/13/2024 at 4:09pm, the DON was shown Resident #29's lab orders for 6/6/2024. She said there was a lab order for 6/24/2024 but not for 6/6/2024. When asked why there would be two orders in the system, the DON replied that the two orders placed on 6/6/2024 and 6/24/2024 could be routine labs done for long-term care residents or in preparation for residents' doctor's visits. The DON would need to look into the lab order placed on 6/6/2024, as she needs to look for the original labs in the system. The facility did not provide the lab results by the end of survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35897 Based on observation and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to ensure expired foods were discarded. 2. The facility failed to ensure foods were labeled and dated. 3. The Facility failed to ensure food was stored in designated areas at all times. 4. The facility failed to thaw frozen ,d+[DATE] lb. rolls of frozen ground beef. These failures could place residents who ate food from the kitchen at risk of food borne illness and disease. Findings Included: Observation of the facility kitchen on [DATE] at 8:15 AM revealed the following. 1. A Plastic Container of Pureed sausage saved from breakfast dated [DATE] use by date [DATE] 2. A Plastic container of Sour cream dated [DATE] no use by date 3. A Plastic Container of ,d+[DATE]lb ground beef submerged in water with temperature of 78.8 degrees Fahrenheit , the ground beef Temperature was 67.4 degrees Fahrenheit. 4. Several boxes food on floor kitchen, walk in refrigerator, in freezer and in storeroom. 5. Scoop left in flour bin. 6. Sugar bin and thickener bin not covered. Interview with the Dietary Food Service Manager on [DATE] at 8:25 AM she stated the leftover food stored in the refrigerator should have been used or discarded prior to use by date, she further stated that all food shall be stored 6 inches off the floor. She also stated that the proper thawing of frozen meat water should be running with a temperature of 70 or below degrees Fahrenheit and the meat should have at temperature of 41 degrees or lower. The Dietary Food Service Manager in-serviced the Dietary staff on Thawing and Cooling Procedure and a post test on [DATE]; Procedure on Expired Products on [DATE]; Procedure on Dietary Leftover Food and Procedure on dating /opening products on [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's policies and procedures for Food Safety for Residents dated 2022 read in part . cover, label with name, date stored and Record review of facility's policies and procedures for Food Storage dated 2022 read in part .store all items at least 6 inches above the floor with adequate clearance between goods and other contamination.

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	455333	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharpview Residence and Rehabilitation Center	7505 Bellerive Houston, TX 77036

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for five of six residents, (Resident #5, Resident #10, Resident #13, Resident #136 and Resident #186) and three of four staff (LVN A, LVN B, CNA A, RN A) reviewed for infection control and prevention, in that: 1. Resident #186's pressure sore treatment was not done with the clean technique. 2. CNA A did not perform hand hygiene before or after Resident #10 nor Resident #13's incontinence/indwelling catheter care. 3.4. LVN did not follow proper technique in cleaning accu-check machine between Resident #136 and Resident #5. These failures placed residents at risk for the development and transmission of infectious diseases, urinary infections, respiratory infections, hospitalization s and death. Findings included: Record review of Resident #186's facility admission record dated 6/14/2024 revealed an admitted [DATE]. Resident #186 was an [AGE] year-old male with diagnoses that included dysphagia (difficulty swallowing), tracheostomy status ((also called a tracheostomy) is a procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe (trachea) to help you breathe) and gastrostomy status (a surgical opening into the stomach for nutritional support or gastric decompression). Record review of Resident#186's baseline care plan dated 5/29/2024 revealed care plans for tracheostomy care, suctioning and skin risk-pressure ulcer at sacrum. Record review of Resident #186's care plan, dated 06/12/24 11:31 am reflected: -Resident #186 is at risk chronic pain r/t Wound at sacrum: Resident #186 will display a decrease in behaviors of inadequate pain control: irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, and groaning through the review date. Record review of Resident #186's Admission MDS dated [DATE], revealed that the Brief Interview for Mental Status was blank. Section GG for ADL's revealed Resident #186 was total dependent on staff. Observation of Resident #186's pressure ulcer on 6/12/24 at 1:01 PM, performed by RN A, she cleaned the stage 2 pressure ulcer to the sacral area stage 2, RNA poured normal saline on 4 x4 gauze, with gloved hand she cleaned, RN A cleaned the wound in a circular form around the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with RN A on 6/12/24 at 1:18 PM regarding cleaning Resident #186's pressure ulcer, RN A said she always cleaned the pressure wound in a circular motion and she had in-services on wound cleaning, and she could not remember when she had in-services on wound care. In an interview with the DON on 6/12/24 at 4:30 PM regarding the cleaning pressure ulcer wounds she said, nurses were supposed to clean pressure ulcer from the center outward. Record review of Resident #10's face sheet revealed an [AGE] year-old resident who was originally admitted to the facility on [DATE]. Her medical diagnoses included cerebrovascular disease (variety of medical conditions that affect the blood vessels of the brain and the cerebral circulation), type 2 diabetes mellitus, hyperlipidemia (high levels of fat in the blood), hypothyroidism (the thyroid gland does not produce enough hormones), Anxiety Disorder, Malignant Neoplasm of Female Breast, Hypertension (high blood pressure), Hemiplegia and Hemiparesis following cerebral infarction (stroke) affecting left non-dominant side, dysphagia (difficulty swallowing), and generalized muscle weakness. Record review of Resident #10's quarterly MDS dated [DATE], the resident's BIMS (brief interview that measures cognitive intactness) score was a 14, indicating she was cognitively intact. Further review showed the resident was always incontinent of urine and bowel. Record review of Resident #10's care plan dated 05/22/2024, her focus areas included: -I have bowel incontinence, dated 11/28/2023. Interventions included: checking resident every two hours and assisting with toileting as needed, provide bedpan/beside commode, provide peri care after each incontinent episode, take resident to toilet each day to try to establish a bowel pattern: I have an ADL self-care performance deficit r/t Hemiplegia and Hemiparesis affecting Left non-dominant side s/p cerebrovascular attack, Interventions included: Toilet use, with the resident being totally dependent on one staff for toilet use. Record review of Resident #13's face sheet revealed an [AGE] year-old who was originally admitted to the facility on [DATE]. Her medical diagnoses included Type 2 diabetes mellitus (high glucose in the blood), urinary tract infection, immunodeficiency due to conditions classified elsewhere, inflammatory Poly arthropathy, retention of urine, vascular dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #13's admission MDS dated [DATE], the resident's BIMS (brief interview that measures cognitive intactness) score was blank, indicating she was cognitively intact. BIMS score of blank meaning Resident #13 was severely impaired. Resident #13 was always continent of urine using indwelling catheter and incontinent bowel. Record review of Resident #13's care plan revised 05/08/2024 revealed resident was care-planned for the following: Resident #13 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Activity intolerance, impaired balance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions for Toilet Use: The resident is totally dependent on (x 1) staff for toilet use, Resident #13 has bowel incontinence r/t immobility, poor gait & balance -Interventions: Check resident frequently and assist with toileting as needed, Provide peri care after each incontinent episode Record review of Resident #13's MAR (Medication Administration Record) for May 2024 revealed resident was on Macrobid (medication used for urinary tract infection for 7 Days) and she just completed on 5/18/24. Observation of Resident # 13's Foley catheter care on 06/11/24 at 08:52 AM was lying in bed, with eyeglasses on, she had indwelling catheter. Further observation on 6/11/24 at 10:00AM, CNA A was at bedside to perform incontinent / indwelling catheter care, don gloves but did not wash hands., CNA A placed indwelling, Foley catheter on the bed with 50cc of yellow urine in the bag and urine along the tubing, she wipe resident, groin, and perineal area, she did not open the labia to cleaned, she cleaned the tubing, she repositioned resident on her left side, then pulled down the brief from the back, Resident #13 had large bowel movement (BM), CNA A then change gloves, did not washed hands or use hand sanitizer and picked a cleaned gloves from her uniform pocket, cleaned in/between the buttocks, she did not cleaned around the buttock did not change gloves, then placed a clean brief on Resident #13. Observation on 6/11/24 at 10:25 AM Resident #10 was lying in bed, CNA A washed hands and donned (put on) clean gloves, using the wet wipes, CNA A cleaned Resident #10's groin, and did not open the labia to clean. CNA A repositioned to the left side, Using the wet wipes, CNA A cleaned in between buttocks, she did not clean the around the buttocks. The CNA A picked up cleaned brief put it on Resident #10 without changing gloves. CNA A used the same gloves throughout the procedure. Interview with CNA A on 6/11/24 at 11:30 AM, regarding Resident #10's incontinent and indwelling catheter care, she said she started working December 2023, and she thought she did a good job. C.NA A was off duty and was not picking telephone calls. During an interview with the DON on 06/13/2024 at 2:25 PM., the DON stated that during the incontinent care of a female resident, Staff should wipe the peri area, then open the labia and clean downward and clean the indwelling catheter in a circular motion. The DON said she was going to start incontinence care skills checks. DON said the ADON and they do incontinent monitoring. The DON stated that if staff performed peri care deviating from policy, residents risked possible urinary infections. The DON did not have policy for incontinent and Foley catheter care. In an interview on 06/13/2024 at 2:35 PM, the Administrator stated her expectation was that incontinent care and hand washing were always done to prevent infection. Interview with ADON on 6/13/24 at 4:15 PM she said Resident#13 just completed Macro antibiotic bid on 5/18/24 for UTI (urinary tract infection). Record review of Resident #5's face sheet revealed [AGE] year-old resident who was originally admitted to the facility on [DATE]. Her medical diagnoses included type 2 diabetes mellitus without complications (high levels of fat in the blood), morbid (severe) obesity due to excess calories, diabetic neuropathy, unspecified psychosis not due to a substance or known physiological condition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's admission MDS dated [DATE], the resident's BIMS (brief interview that measures cognitive intactness) score was a 15, indicating she was cognitively intact. Record review of Resident #5's Care plan revealed he had an ADL self-care performance deficit r/t impaired mobility New Goal The resident will improve current level of function through the review date. Record review of Resident #5's physician's order dated 05/14/2024, revealed accu-check before each meal. Record review of Resident #136's face sheet revealed [AGE] year-old resident who was originally admitted to the facility on [DATE] readmitted [DATE]. Her medical diagnoses included type 2 diabetes mellitus without complications (high levels of fat in the blood), morbid (severe) obesity due to excess calories (excess weight gain) multiple myeloma (blood cancer) not having achieved remission. Record review of resident #136's quarterly MDS dated [DATE], the resident's BIMS (brief interview that measures cognitive intactness) score was a 08, indicating she was moderately cognitively intact. Record review of Resident #136's Care plan I have an ADL self-care performance deficit r/t impaired mobility New Goal The resident will improve current level of function through the review date. - Record review of Resident #136's physician's order dated 03/28/2024, revealed accu-check before each meal. Observation on 6/11/24 at 4:19 PM of Resident #136's care blood glucose (BG) done by LVN B, LVN B picked up accu-check from the medication cart to Resident #136's room, she used the lancet and struck Resident #136's finger and drop blood on blood glucose strip. BG was 142mg/dl. Observation on 6/11/24 at 4:33 PM, LVN B did not wipe down the accu-check machine, between Resident #136's and Resident #5's BG checks. LVN B checked Resident #5's BG was 213mg/dl. In an interview with LVN B on 6/11/24, at 4:38 PM she was very sorry for not wiping the accu-checks in-between the Resident #136 and Resident #5. It could cause contamination. She said she had in-services on infection control. In an interview with DON on 6/12/24 at 5:00PM regarding accu-check machine cleaning during blood glucose checks. DON said LVN B were supposed to clean the accu-check machine between residents BG checks to prevent infection. DON said she would be conducting in-services on accu-check. Record review of undated policy for Hand Hygiene revealed: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 3. Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. 4. Hand hygiene technique when using an alcohol-based hand rub: a. Apply to palm of one hand the amount of product recommended by the manufacturer. b. Rub hands together, covering all surfaces of hands and fingers until hands feel dry. c. This should take about 20 seconds. 5. Hand hygiene technique when using soap and water: a. Wet hands with water. Avoid using hot water to prevent drying of skin. b. Apply to hands the amount of soap recommended by the manufacturer. c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. Rinse hands with water. e. Dry thoroughly with a single-use towel. f. Use clean towel to turn off the faucet. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. b. Bar soap is approved for a resident's personal use only. Keep bar soap clean and dry in protective containers (i.e. plastic case or bag). Record review of undated policy for catheter care revealed Catheter Care Under Policy Explanation . #9. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. Record review of the facility policy undated for clean dressing change: Policy: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and /or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. Policy explanation and compliance guidelines: 12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e. clean outward from the center of the wound). Pat dry with gauze. (continued on next page)

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