STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Trail Nursing and Rehabilitation Center	930 S Baxter Tyler, TX 75701

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observation, interview and record review, the facility failed to ensure accurate MDS assessments were completed for 4 of 6 Residents (#16, #50, #60, #61) reviewed for accuracy of MDS assessments. The facility failed to accurately code Residents #16's and #50's quarterly MDS assessments for dialysis. The facility incorrectly coded Residents # 60's and #61's comprehensive MDS assessments for ventilator use. These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being. Findings included: 1.A review of Resident #16's face sheet and physician's orders for September 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included end-stage renal disease (condition in which the kidneys lose their ability to remove wastes and balance fluids) and dependence on dialysis (process of removing water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions). A review of Resident #16's quarterly MDS (Section O: J-1dated 08/15/2024 indicated she had not received any dialysis during the observation period. A review of Resident #16's physician's order dated September 2024 indicated she had an order dated 04/28/2024 to receive dialysis treatments three (3) days a week at a local dialysis center. During an interview with Resident #16 on 09/23/2024 at 08:25 AM, she said she went to the dialysis center three (3) days a week on Monday-Wednesday-Friday and had been receiving dialysis for [AGE] years. 2. A review of Resident #50's face sheet and physician's orders for September 2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included end-stage renal disease and dependence on dialysis. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #50's quarterly MDS (Section O: J-1) dated 09/06/2024 indicated she had not received any dialysis during the observation period. A review of Resident #50's physician's order dated September 2024 indicated she had an order dated 04/28/2024 to receive dialysis treatments three (3) days a week at a local dialysis center. During an interview with Resident #50 on 09/23/2024 08:50 AM, she said she went to the dialysis center three (3) days a week. 3. A review of Resident #60's face sheet and physician's orders for September 2024 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included TBI (traumatic brain injury), chronic respiratory failure, and tracheostomy status (artificial opening in the windpipe that allows air to enter the lungs). Record review of the comprehensive MDS dated [DATE] indicated Resident #60 was in a vegetative state/without discernible consciousness and was dependent on others for activities of daily living. Further review of the same MDS (Section O: Respiratory Treatments: F1, G1) indicated he was receiving ventilator therapy (a ventilator, also referred to as a vent, is a type of breathing apparatus that helps a person breath or breathes for a person when he/she cannot breathe on his/her own). A review of Resident #60's physician's orders dated September 2024 indicated he had an order dated 06/15/2024 to receive humidified oxygen therapy via a tracheostomy collar. There was no order for Resident #60 to have a ventilator. During observation of Resident #60 on 09/23/2024 at 10:51 AM, he was noted lying in bed with the head of the bed elevated. He was noted to be wearing a tracheostomy collar and was receiving humidified oxygen by way of tubes connected to an oxygen concentrator and a medical air compressor. There was no ventilator in the room. 4. A review of Resident #61's face sheet and physician's orders for September 2024 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included TBI (traumatic brain injury), chronic respiratory failure, and tracheostomy status. Record review of the comprehensive MDS dated [DATE] indicated Resident #60 was in a vegetative state/without discernible consciousness and was dependent on others for activities of daily living. Further review of the same MDS (Section O: Respiratory Treatments: F1, G1) indicated he was receiving ventilator therapy. A review of Resident #61's physician's orders dated September 2024 indicated he had an order dated 03/20/2024 to receive humidified oxygen therapy via a tracheostomy collar. There was no order for Resident #60 to have a ventilator. During observation of resident #61 on 09/23/2024 at 10:51 AM, he was noted lying in bed with the head of the bed elevated. He was noted to be wearing a tracheostomy collar and was receiving humidified oxygen by way of tubes connected to an oxygen concentrator and a medical air compressor. There was no ventilator in the room. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with RN Consultant on 09/23/2024 at 09:10 AM, she said the facility did not have any residents on vent services. She said the MDS assessments were incorrectly coded. During an interview with the LVN MDS Nurse on 09/25/2024 at 11:25 AM, she said she was new to the facility and did not know why the previous MDS Nurse did not code Residents #16 and #50 for receiving dialysis therapy. She also said she did not know why the previous MDS nurse incorrectly coded residents # 60 and #61 for being on vent services. During an interview with the MDS Consultant Nurse on 09/25/2024 at 11:30 AM, she said she did not know why the previous MDS Nurse incorrectly coded the MDS assessments in question. She said the facility used the RAI Version 3.0 Manual as the policy for completing MDS assessments. The previous MDS Nurse was no longer employed at the facility and was not available for interview. A review of the facility's policy dated 07/2022 and titled MDS 3.0 Completion indicated the following: Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan., . 1.According to federal guidelines, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. A review of the RAI Version 3.0 Manual: Section O: Special Treatments, Procedures, and Programs indicated the following: The treatments, procedures, and programs listed in Item O0100, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life. Planning for Care: Reevaluation of special treatments and procedures the resident received .is important to ensure the continued appropriateness of the treatments, procedures, or programs.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140 Based on interview and record reviews, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review Level 1(PASRR) Screening for 2 of 5 residents reviewed for PASRR (Resident #36 and #57). The facility failed to ensure Resident #36 had an accurate PASRR Level 1 Screening indicating a diagnosis of mental illness on 9/20/2021. The facility failed to ensure Resident #57 had an accurate PASRR Level 1 Screening indicating a diagnosis of mental illness on 5/10/2023. These failures could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: 1. Record review of a face sheet dated 04/10/2024 indicated Resident #36 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder, depression, and seizures. Record review of the significant change MDS assessment dated [DATE] indicated, Resident #36 had a BIMS score of 11 (eleven) indicating mildly impaired cognition. The MDS section for PASRR (A1500) indicated Resident #36 did not have a serious mental illness. The MDS Section I, Psychiatric/Mood Disorder, indicated Resident #36 had diagnoses of depression and bipolar disorder. Section N of the same MDS assessment indicated Resident #36 had received antidepressants and anxiolytic medications for 7 of 7 days of the assessment period. Record review of the quarterly MDS assessment dated [DATE] indicated, Resident #36 had a BIMS score of 11 (eleven) indicating mildly impaired cognition. The MDS Section I, Psychiatric/Mood Disorder, indicated Resident #36 had diagnoses of depression and bipolar disorder. Section N of the same MDS assessment indicated Resident #36 had received antidepressants and anxiolytic medications for 7 of 7 days of the assessment period. Record review of Resident #36's PASRR Level 1 Screening completed on 09/20/2021 indicated in section C0100 there was no evidence of this individual having mental illness. 2. Record review of a face sheet dated 04/10/2024 indicated Resident #57 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and anxiety disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the admission MDS assessment dated [DATE] indicated, Resident #57 had a BIMS score of 03 (three) indicating severely impaired cognition. The MDS section for PASRR (A1500) indicated Resident #57 did not have a serious mental illness. The MDS Section I, Psychiatric/Mood Disorder, indicated Resident #57 had diagnoses of depression and bipolar disorder. Section N of the same MDS assessment indicated Resident #57 had not received antipsychotic or anxiolytic medications for 7 of 7 days of the assessment period. Record review of the quarterly MDS assessment dated [DATE] indicated, Resident #57 had a BIMS score of 03 (three) indicating severely impaired cognition. The MDS Section I, Psychiatric/Mood Disorder, indicated Resident #57 had diagnoses of depression and bipolar disorder. Section N of the same MDS assessment indicated Resident #57 had not received antipsychotic or anxiolytic medications for 7 of 7 days of the assessment period. Record review of Resident #57's PASRR Level 1 Screening completed on 06/14/2023 indicated in section C0100 there was no evidence of this individual having mental illness. During an interview on 09/25/2024 at 3:25 PM, the MDS nurse said the MDS department was responsible for PASRR functions. She said the MDS nurse was assigned the task of reviewing the Level 1 PASRRs to ensure accuracy and appropriate follow-up actions. She said the person who would have reviewed Resident #36's PASRR I was no longer working at the facility. She said the LA should have been notified of the inaccurate PASRR Level I. The MDS nurse said the LA should have been notified of Resident #57s incorrect PASRR Level I also. The MDS Nurse said she understood the importance of PASRR Level 1 Screenings being accurate because the facility needed to make sure eligible residents were getting the correct resources.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observation, interview and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs of 3 of 5 residents reviewed for pharmacy services (Residents #45, #57, and #173). The facility failed to ensure the physician's order for Vitamin C included the dose of Vitamin C to be administered to Resident #45. The facility failed to ensure three (3) physician prescribed medications including Vitamin B12 (a vitamin present in foods of animal origin), Brimonidine tartrate ophthalmic (refers to the eye) solution (eye drops to treat glaucoma, a condition wherein the nerve connecting the eye to the brain is damaged and can result in blindness)), and Latanoprost ophthalmic eye drops (to treat glaucoma) were available for administration to Resident #57 as ordered by the physician. The facility failed to obtain a stop date for an antibiotic dated 9/16/2024 per the hospital discharge summary, resulting in Resident #173 receiving the medications beyond the intended stop date. These failures could place residents at risk for not receiving their medications as ordered and resulting in a decline in health and decreased quality of life. Findings included: 1. A review of Resident #45's face sheet and physician orders dated 09/24/2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included epilepsy, systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs) cerebral infarction (stroke), hemiparesis of the right side (right-sided paralysis), atrial fibrillation (heart disorder), and a history of blood and blood-forming organs. During observation of medication administration on 09/24/2024 at 08:40 AM, MA C was observed to administer one Vitamin C 500mg tablet (helps the immune system work properly) to Resident #45. A review of Resident #45's physician orders indicated an incomplete order, initiated on 05/06/2022, for 1 tablet Vitamin C to be given two times daily. The order did not include the dose to be administered. A review of Resident #45's MAR dated for September 2024 indicated incomplete instructions for 1 tablet of Vitamin C to be administered two times daily. The order did not specify the dose of Vitamin C to be administered. A review of pharmacy reviews for the months of July, August, and September 2024 indicated the facility's pharmacy had not addressed the incomplete order of Vitamin C regarding the specific dose of Vitamin C to be administered twice daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.A review of Resident #57's face sheet and physician orders dated for 09/24/2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included protein calorie malnutrition and glaucoma (a condition wherein the nerve connecting the eye to the brain is damaged and can result in blindness). During observation of medication administration on 09/24/2024 at 09:25 AM, RN D did not administer two (2) physician prescribed medications which included 1 tablet Vitamin B12 100mcg and Brimonidine tartrate ophthalmic solution 0.2% (eye drops) one (1) drop each eye to Resident #57. After a search of the medication cart and medication rooms, it was determined the medications were not available for administration. A review of Resident #57's physician's orders dated for September 2024 was observed to include an order dated 05/11/2023 for 1 tablet of Vitamin B12 100mcg to be administered one time daily and an order dated 05/26/2024 for one drop (1) of Brimonidine tartrate ophthalmic solution 0.2% to be instilled into each eye three times daily. A review of Resident #57's MAR dated for September 2024 indicated the Vitamin B12 100mcg tablet and the Brimonidine ophthalmic solution were documented as not being administered on 09/24/2024 at 09:25 AM due to unavailability. Further review of Resident 57's September MAR on 09/25/2024 indicated Resident #57 did not receive any of the three scheduled (3) doses of Brimonidine ophthalmic solution on 09/24/2025 due to unavailability. Instructions to administer one (1) drop of Latanoprost 0.005% ophthalmic solution was also noted as not being administered on the evening of 09/24/2024. Further review of Resident #57's physician orders indicated Resident #57 did have an order for one (1) drop of Latanoprost ophthalmic solution to be administered every evening. 3.A review of Resident #173's face sheet and physician's orders for September 2024 indicated he was a [AGE] year-old male who admitted [DATE] with diagnosis which included acquired absence of right leg below knee, age-related cognitive decline, cognitive communication deficit, muscle wasting and atrophy, not elsewhere classified, multiple sites, and paroxysmal atrial fibrillation, type 2 diabetes mellitus with diabetic neuropathy. A review of Resident #173's physicians order dated 8/27/2024 indicated he was to receive Levofloxacin 750 mg tablet, orally once a day. There was no stop order for this antibiotic. A review of Resident #173's care plan dated 9/17/2024 indicated Antibiotics and Nurse to monitor. During an interview with RN D on 09/24/2024 at 09:45 AM, she said she did not have any B12 100mcg tablets nor the Brimonidine ophthalmic solution in her cart. She said she checked the cart and med rooms and did not find any of the two (20 medications. She said the RN Nurse Consultant told her to call the doctor and obtain clarification of the Vitamin B12 dose and to call the pharmacy and ask them to stat out the Brimonidine eye drops. RN D explained stat out meant the pharmacy would either send it or get another local pharmacy to send it out to the facility immediately. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN A on 09/24/2024 at 11:30 AM, she said she was the charge nurse, and she would check on why there was not a stop date on antibiotic for resident#173. She said she was the nurse responsible for transcribing the orders and acknowledged to the surveyor that she had not read the hospital discharge summary and did not ask for a stop date from the hospital physician or medical director. She said but she would check with the medical director for orders and currently there was no monitoring for adverse reactions being done. During an interview with the IP Nurse on 09/25/2024 at 11:40 AM, she said she was new at this job, just got her certification 9/18/2024, and was still learning the policies on antibiotic stewardship. During an interview with the ADON on 9/24/2024 at 11:45 AM, he said all antibiotics are to have an end date per facility policy. During an interview with the DON on 09/25/2024 at 11:50 AM, he said he expected medications to be administered as ordered to prevent negative results that could adversely affect the residents. He said that according to facility policy all antibiotics should have a stop date. He said the facility did not have a contract with infectious disease and they use the policy on Antibiotic Prescribing Practices and will have to call the medical director to get a stop date and appointment for follow up with infectious disease for stop order. A review of the facility's policy titled Pharmacy Services and dated 07/2022 indicated the following: Policy: It is the policy of this facility to ensure that pharmacological services .are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. A review of facilities policy titled Antibiotic Stewardship Program, dated 06/2022 indicated the following: Policy: All prescriptions for antibiotics shall specify the dose, duration and indication for use. A review of facilities policy titled Antibiotic Prescribing Practices indicated the following: Policy: The facility will utilize a 5D's approach to antibiotic prescribing: a. Diagnosis b. Drug c. Dose d. Duration: Documentation shall include start date, end date and planned days of therapy e. De-escalation - reassessment of empiric precautions will be conducted after 2-3 days or appropriateness.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observation, interview, and record review, the facility failed to ensure a medication error rate less that 5 percent. There were 3 errors out of 31 opportunities, resulting in a 9 percent medication error rate involving 2 of 4 residents (Residents #45 and #57) reviewed for medication administration. MA C administered Vitamin C to Resident #45 without verifying the dose to be given. RN D failed to administer Vitamin B12 and Brimonidine ophthalmic solution 2% to Resident # 57 as ordered by the physician. These failures could place residents at risk for inaccurate drug administration resulting in a decline in health and decreased quality of life. Findings included: 1.A review of Resident #45's face sheet and physician orders dated 09/24/2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included epilepsy, systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs) cerebral infarction (stroke), hemiparesis of the right side (right-sided paralysis), atrial fibrillation (heart disorder), and a history of blood and blood-forming organs. During observation of medication administration on 09/24/2024 at 08:42 AM, MA C administered medications to Resident #45 which included one (1) tablet of Vitamin C 500mg. Record review of the Resident #45's physician orders dated for 09/24/2024 indicated an incomplete order, initiated on 05/06/2022, for one (1) tablet of Vitamin C to be administered twice daily. The order did not include the dose of Vitamin C to be administered. 2. A review of Resident #57's face sheet and physician orders dated for 09/24/2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included protein calorie malnutrition and glaucoma (a condition wherein the nerve connecting the eye to the brain is damaged and can result in blindness). During observation of medication administration on 09/24/2024 at 09:25 AM, RN D was observed to administer two (2) medications (metoprolol and apixaban) to Resident #57 via the Resident's gastrostomy tube. Record review of Resident #57's physician's orders dated for September 2023 indicated Resident #57 was also to receive one (1) tablet of Vitamin B12 100mcg and one (1) drop of Brimonidine 2% ophthalmic solution instilled in each eye. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	These two (2) medications were not administered the observed medication pass at 09:25 AM on 09/24/2024. During an interview on 09/25/2024 at 09:10 AM with MA C, she said she had not noticed the order for Vitamin C was missing the dose to be given. She said Vitamin C 500mg was the dose she was used to giving the other residents. MA C said she should have observed the basic rights of medication administration and if she had, she would have noticed the dose was missing and told the charge nurse. She said the basic Rights of Medication Administration included checking for the right dose of medications to be administered. During an interview with RN D on 09/24/2024 at 09:35 AM, she said she did not have any Vitamin B12 100mcg tablets nor did she have any Brimonidine eye drops to administer to Resident #57. She said she could not locate any in the facility's emergency supply, the medication carts, nor the medication rooms. She said the RN Consultant told her to call the physician and get the Vitamin B12 and Vitamin C doses verified. She said the RN Consultant also told her to call the pharmacy and ask them to stat out the Brimonidine eye drops. RN D explained stat out meant the pharmacy would either send it or get another local pharmacy to send it out to the facility immediately. During an interview with the DON on 09/25/2024 at 11:40 AM, he said he expected medications to be administered as ordered to prevent negative results that could adversely affect the residents. During an interview with the RN Nurse Consultant on 09/25/2024 at 11:00 AM, she said Resident #45's Vitamin C order had been clarified to read one tablet of Vitamin C 500mg twice daily. She said the Vitamin C order had probably been incomplete since it was initially written. She said Resident #57's Vitamin B12 order had been clarified and changed to Vitamin B12 1000mcg daily. She said Resident #57's Brimonidine and Latanoprost ophthalmic solutions had been delivered and the physician was made aware of the missed doses. She said she did not know why the eye drops were not delivered on 09/24/2024. A review of the facility's policy dated 07/2022 and titled Pharmacy Services included the following: Compliance Guidelines: 8. The pharmacist, in collaboration with the facility and medical director, should include within its services to: f. strive to assure that medications are requested , received, and administered in a timely manner as ordered by the authorized prescriber . A review of the facility's policy dated and titled Medication Administration indicated the following: 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. 10.Ensure that the six rights of medication administration are followed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Right resident b. Right drug c. Right dosage ** d. Right route e. Right time f. Right documentation.

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	455429	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Trail Nursing and Rehabilitation Center	930 S Baxter Tyler, TX 75701

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observations, interviews, and record reviews, the facility failed to implement infection prevention and control practices designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Residents #57) reviewed for medication administration procedures. RN D obtained a syringe sealed in a plastic bag from the floor of Resident #57's room and used it for administration of water and medications through a gastrostomy tube after contaminating the syringe plunger by placing it on the plastic bag that had been lying on the floor. This failure could place residents who receive medications, water, or liquid nutrition via a gastrostomy tube at risk for exposure to possible transmission of communicable diseases and infections. Findings included: A review of Resident #57's face sheet and physician orders dated for 09/24/2024 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included gastrostomy tube placement (a tube inserted through the skin into the abdomen for administration of liquid nutrition, water, and medications), protein calorie malnutrition, hypertension, heart failure, and dysphagia (difficulty swallowing). During observation of medication administration via Resident #57's gastrostomy tube on 09/24/2024 at 09:32 AM , RN D was observed to pick up a sealed plastic bag containing a 30ml syringe from the floor beside Resident #57's bed. RN D donned gloves, opened the plastic bag, removed the syringe from the bag, and laid the contaminated plastic bag on Resident #57's bedside table. Without changing gloves nor performing hand hygiene after handling the contaminated plastic bag, RN D used the syringe to check tube placement by inserting the syringe into the gastrostomy tube. RN D then proceeded to remove the syringe plunger from the syringe barrel and placed the plunger on the contaminated plastic gag lying on Resident's bedside table. RN D administered two medications and water via gravity drainage using the barrel inserted into the gastrostomy tube. RN D disconnected the syringe barrel from the tube and inserted the contaminated plunger into the syringe barrel. She then picked up the plastic bag, placed the syringe into the bag, and hung the bag on a pole beside Resident #57's bed. RN D was observed to leave Resident #57's room, discard her gloves, sanitize her hands, go to the medication room, obtain another medication from the emergency medication supply, and then return to Resident # 57's room where she again donned gloves, obtained the contaminated plastic bag with the syringe in it, and used the same syringe to administer the medication to Resident #57 via the gastrostomy tube. RN D was again observed to remove the syringe plunger from the syringe barrel and lay the plunger on the contaminated plastic bag while she administered the medication using the contaminated syringe barrel. After administering the medication, RN D obtained the syringe plunger that was lying on the plastic bag, re-inserted it into the syringe barrel, placed the syringe back into the plastic bag, and hung the bag on the pole beside Resident #57's bed. RN D removed and discarded her gloves, performed hand hygiene, and said she was through. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/24/2024 at 10:45 AM, RN D said she should have discarded the syringe that was on the floor and obtained a new one. She said handling the bag with her gloved hands caused her to contaminate her gloves. She said by laying the syringe plunger on the contaminated bag, she contaminated the plunger and by inserting the plunger back into the syringe barrel, she contaminated the inner barrel of the syringe. She said these actions placed Resident #57 at risk for having germs, bacteria, and/or debris from the floor enter Resident #57's body by way of the gastrostomy tube. During an interview with the DON and RN Nurse Consultant on 09/25/2024 at 11:55 AM, they said RN D's actions were not acceptable and would start the education process. A review of the facility's policy entitled Infection Prevention and Control Program indicated the following: Policy: This facility has established and maintains 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. 4.d. Licensed staff shall adhere to safe injection and medication administration practices . A review of the facility's policy entitled Care and Treatment of Feeding Tubes indicated the following: It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: 7. Direction for staff on how to provide the following care (of feeding tubes) will be provided: d. Use of infection control precautions and related techniques to minimize the risk of contamination.