STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455582	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Villa Healthcare Center	1800 13th St Bay City, TX 77414

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 5 resident (Resident #24) reviewed for incontinent care. -The facility failed to ensure CNA JJ and CNA RR properly cleaned Resident #24 during incontinent care. This failure could place residents at risk for urinary tract infections (UTI), urethral erosions, discomfort, skin breakdown, and a decreased quality of life. Findings include: Record review of the admission sheet (undated) for Resident #24 revealed an [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included pneumonia (Infection that inflames air sacs in one or both lungs, which may fill with fluid), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should) and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage). Record review of Resident #24's Quarterly MDS, dated [DATE], revealed the BIMS score was 14 out of 15, which indicated she was intact cognitively. The MDS revealed she was dependent from staff with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS revealed in section H0300: Urinary Incontinence was coded (3) always incontinent. section H0400: Bowel Incontinence was coded (3) always incontinent. Record review of Resident #24's care plan, initiated 05/21/2021 and revised on 09/01/2023 revealed the following: Focus: Resident#24 has bowel and bladder incontinence and is at risk for skin break down AEB cognitive impairment. Goal: Resident#24 will remain clean, dry, odor free and no occurrence of skin breakdown will occur over the next 90 days. Interventions: Change promptly and apply a protective skin barrier to the skin 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/27/24 at 2:33p.m., revealed CNA RR and CNA JJ provided Resident #24 with incontinence care. CNA JJ removed Resident #24's brief and tucked it under the resident's buttocks. CNA JJ did not spread Resident #24's labia to thoroughly clean the area and the resident's urinary meatus. In an interview on 03/27/24 at 2:44p.m., with CNA JJ, she said she had been working at the facility for the last 7 years as a full-time employee. CNA JJ said she did not spread Resident's labia and clean the resident's meatus during incontinent care because I was nervous. She said the failure placed the resident at risk for infections. In an interview on 03/28/24 at 1:24 p.m., with the DON, she said she expected staff to make sure they provided complete and proper incontinent care. She said CNAs were provided training and competency check offs quarterly and as needed. At this time policy on perineal care was requested. No policy on Perineal Care was provided on exit. Record review of CNA JJ's Peri Care Competency Check off dated 01/26/23 and 01/8/24 revealed read in part: .FEMALE considerations: Helps to flex knees and spread legs apart. Observe limitations in positioning. Utilize bath towels or washcloths as indicated. Separate the labia, cleanse front to back with a disposable wipe using downward strokes. Discard soiled gloves, wash hands, and DON clean gloves. Apply barrier cream. Apply clean undergarment/brief as necessary. Remove gloves, wash hands, and dispose of linen properly .

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48863 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, and disposing of expired medications) to meet the needs of each of resident for 1 (resident #27) of 5 residents reviewed for gastrostomy (G-tube) medication administration in that: LVN A's cart contained an insulin Glargine injection pen100 units/ML prefilled expired 03/26/24, and LVN B's Enoxaparin 40mg/.4ml prefilled syringes expired on 03/27/24. LVN A's cart contained expired low control glucose control solutions. expired 12/23 and the high control expired 01/24. These failures could place residents with G-tubes (Gastrostomy tube) at risk of g-tube replacement, medical complications, or a decline in health due to inappropriate G-tube care, management, and not following appropriate procedures. Findings Include: Observation on 3/27/24 at 9:30 a.m. of medication administration via g-tube , one (MiraLAX) medication cup with condensation noted and two additional medication cups for G-tube medication administration at bedside. LVN checked residual as ordered and administered 30 milliliters (mls) of water initial [NAME] via gravity but used plunger to initiate the 30mls of water flow. She removed the plunger and administered liquid medications with water flush in between each medication. The cup was noted to still be cool to touch after medication administration. In an interview 03/27/24 at 9:40 a.m. with the LVN A, she said, the cup was cold but has been sitting out for a while to do his g-tube medication. She said the risk of using the plunger and using cold fluids for g-tube was that the resident may feel discomfort . She said, I know I'm not supposed to use it, but it was going in too slow. Observation on 3/27/24 at 10:43 a.m. revealed an insulin Glargine injection pen100 units/ML prefilled with an opened date of 02/27/24; expired located inside of LVN A's cart. Observation on 3/27/24 at 10:44 a.m. revealed high and low glucose control solutions (used to perform Glucose Meter quality checks) expired inside the cart. The low control expired 12/23 and the high control expired 01/24. During an interview on 3/27/24 at 10:45 a.m. LVN A confirmed the insulin Glargine injection 100 units/ML prefilled pen had an expiration date of 3/27/24. She said, it should have been discarded. She said, the risk of having expired insulin was that the resident may not receive the correct amount needed. LVN A said, the evening shift checks controls for the blood glucose meters, and the risk of using expired control solutions to test the blood glucose meters was getting the incorrect reading. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/28/24 at 12:30 p.m. with the ADON, she accompanied this surveyor to LVN B's cart, and she confirmed there were three Enoxaparin 40mg/.4ml syringes with expiration date of 03/27/24. She said, the medications should have been removed from the cart as soon as they were expired, especially since the resident had not returned to the facility after his appointment. Record review of Resident # 27's face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnoses of Displaced fracture of the right humerus (upper arm fracture), aphasia (a language disorder that makes it hard for you to read, write, and say what you mean to say), and aphonia (a loss of voice such as partial hoarseness or complete whisper). Record review of the MDS dated [DATE], revealed Resident #27 had no BIMS score documented. Record review of nurse notes dated 03/27/24 indicated the resident had a change of conditioned on 03/26/24 due to a weak g-tube after several attempts to unstop g-tube. Resident had a new 18 French g-tube exchanged by the physician on 03/26/24 at 1:46 p.m. Observation and interview on 03/28/24 at 12:30 p.m. with the ADON, she accompanied this surveyor to LVN B's cart, and she confirmed there were three Enoxaparin 40mg/.4ml syringes with expiration date of 03/27/24. She said, the medications should have been removed from the cart as soon as they were expired, especially since the resident had not returned to the facility after his appointment. Record review of the facility's policy and procedure titled, Storage of Medications, not dated, read in part . Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations are those of the suppliers. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, our staff members lawfully authorized to administer medication. Procedures:2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to excess medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. Expiration dating (Beyond-use dating):7. No expired medication will be administered to a resident. 8. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47709 48863 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were secured properly for 1 of 5 medication carts reviewed for pharmacy services in that: The facility failed to ensure LVN A did not leave 1 optic medication on top of the medication cart unsupervised. This failure placed residents at risk for unauthorized access to the medication cart and consumption of harmful medications, misappropriation, and drug diversion. Findings included: Observation on 3/27/24 at 10:42 a.m. revealed LVN A's med cart unattended with optic (eye drops) medication located on top of medication cart. During an interview on 3/27/24 at 10:45 a.m. with LVN A, she said, all medications should be locked inside the carts. She said, the risk of leaving eye drops out, was that another resident could pick it up and start using it or drinking it. Record review of the facility's policy and procedure titled, Storage of Medications, not dated, read in part . Procedures: 2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to excess medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. Expiration dating (Beyond-use dating) .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 40249 Based on observation, interview and record review, the facility must dispose of garbage and refuse properly for 1 of 1 dumpster reviewed for garbage disposal. -The facility failed to ensure the dumpster lids and doors were secured. This failure could place residents at risk of infection from improperly disposed garbage. Findings included: Observation on 03/26/24 at 8:41 a.m., revealed the facility's dumpster area, which was in the lot on back side of the facility had a commercial size with top lid completely open. Interview on 03/26/24 at 8:45 a.m., with the Dietary Manager, she stated it was the dietary responsibility that the dumpster doors always must be closed to keep insects and trash out of the dumpster and from entering the facility. She stated housekeeping might have left it open because they throw night's trash out in the morning. In an interview on 03/26/2024 at 3:03p.m., with the Administrator and the DON, the Administrator said she expected the dumpster to be completely closed, and if it was found open, then it should be closed. She said failure to close the lid could cause trash coming out and infection control issue. The DON said the facility would re-educate and monitor that it stayed closed. Record review of the facility's waste Disposal policy (Revised 6-2019) revealed read in part: .Policy: Waste will be disposed of in a manner to prevent transmission of disease, nuisance or breeding place for insects and feeding places for rodents and other mammals. PROCEDURES: 5. Cover waste containers and close dumpsters at all times .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863 Based on interviews, and record review the facility failed to ensure clinical records were maintained in accordance with accepted professional standards and practices, were complete, and accurately documented for 1 (Resident #13) of 5 residents reviewed for clinical records. LVN B failed to document Insulin administration on the eMAR on 03/04/24, 03/11/24, 03/15/24,03/19/24, 03/20/24 and 03/27/24. This failure could place residents at risk inappropriate and inadequate medication administration and a decline in health status. Findings included: Review of Resident #13's revised face sheet dated 03/27/24 reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses including, type 2 diabetes mellitus with unspecified complications (high blood sugar), essential (primary) hypertension (high blood pressure), and cerebral infarction (disrupted blood flow to brain). Record review of Resident# 103's MDS assessment, dated 02/01/24, revealed that his BIMS score was a 09 (Moderate cognitive impairment). Record review of Resident #13's Physician's orders dated on 8/22/23 for Novolog Injection solution 100 unit/ml revealed, Inject sliding scale: if 150-200=3 units; 201-250=5 units; 251-300= 7 units; 301-350 =10 units; 351-400=12 units; If Blood sugar greater than 400, give 12 units and call MD immediately. Record review of Resident #13's March 2024 eMAR and eTAR revealed the following blood sugars without documented nursing interventions (medication administration and/or contact made to physician): 3/04/2024 at 0800: 463 mg/dl 3/04/2024 at 1600: 444 mg/dl 3/11/2024 at 1600: 463 mg/dl 3/15/2024 at 1600: 444 mg/dl 3/19/2024 at 1600: 440 mg/dL 3/20/2024 at 1600: 427 mg/dL 3/27/2024 at 0800: 540 mg/dl (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON and the Regional nurse on 3/27/24 at 1:05 p.m., the DON and Regional Nurse were not aware of the elevated Blood glucose for Resident #13. They said that the expectation was to contact the MD immediately if the resident's blood glucose levels were outside the sliding scale parameters as ordered. The Regional nurse said, there was no risk because the nurse administered the 12 units of insulin and contacted the doctor; however, she just did not document her interventions . The DON stated that the risk of not documenting any interventions was that other nurses were not aware of what was going on with the resident and the need for proper follow-up by the staff. During an interview on 3/27/24 at 2:46 p.m. with LVN B, she stated, she checked the Sliding scale order for Resident #13 based on the eMAR, and the resident had a BS of 540 mg/dl which was on her personal notepad . She said she called the doctor and administered 12 units of Insulin but does not know the exact time. She said, if the resident's blood sugar reading was too high or too low, the system would not allow her to add the medication on the eMAR, and the progress notes would populate. LVN B said, she contacted the NP today and left a voicemail message. She rechecked resident A's blood sugar around 11:00 a.m. and it was down to 449 mg/dl. She said, she contacted the doctor because the NP had not called back. She said, when the MD called, he gave a new order for 15 units of Levemir between 1:45pm-200pm. LVN said, she should have documented in the nurse's notes that she contacted the physician and documented on the MAR that 12 units of insulin was administered. She said, if it isn't documented, it means that it wasn't done. LVN B said, the risk of not documenting was that someone else could have administered more medications because they would not have known that it was administered based on the MAR. During an interview on 3/28/24 at 2:46 p.m. with the Nurse Practitioner, she said that the initial contact with LVN B was on 03/27/24 at 1:11p.m. LVN B texted the resident's 540 mg/dl blood sugar reading. She stated the text was followed by a call at 1:40 p.m. and a new order was given for regular insulin and a nightly order for Levemir 15 Units. Requested policy for Medication administration from DON, and the policy had not been received by exit.

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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** 40249 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 infection for 1 of 4 residents (Resident #24) reviewed for infection. -The facility failed to ensure CNA JJ and CNA RR performed hand hygiene during incontinent care on Resident #24. This failure could lead to the spread of infection to residents, resident illness, and/or resident distress. Finding include: Record review of the admission sheet (undated) for Resident #24 revealed an [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included pneumonia (Infection that inflames air sacs in one or both lungs, which may fill with fluid), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should) and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage). Record review of Resident #24's Quarterly MDS, dated [DATE], revealed the BIMS score was 14 out of 15, which indicated she was intact cognitively. The MDS revealed she was dependent from staff with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS revealed in section H0300: Urinary Incontinence was coded (3) always incontinent. section H0400: Bowel Incontinence was coded (3) always incontinent. Record review of Resident #24's care plan, initiated 05/21/2021 and revised on 09/01/2023 revealed the following: Focus: Resident#24 has bowel and bladder incontinence and is at risk for skin break down AEB cognitive impairment. Goal: Resident#24 will remain clean, dry, odor free and no occurrence of skin breakdown will occur over the next 90 days. Interventions: Change promptly and apply a protective skin barrier to the skin as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/27/24 at 2:33p.m., revealed CNA RR and CNA JJ provided Resident #24 with incontinence care. CNA JJ removed Resident #24's brief and tucked it under the resident's buttocks. CNA JJ did not spread Resident #24's labia to thoroughly clean the area and the resident's urinary meatus. CNA RR assisted Resident #24 to turn her onto her left side in order to clean her buttocks. Resident had a large bowel movement. CNA JJ without removing her soiled gloves, tucked the clean brief under the resident's buttocks. At this time CNA ZZ knocked on Resisdent#24's door. CNA JJ asked CNA ZZ for the barrier cream and gloves. CNA ZZ handed CNA JJ barrier cream packets and a pair of gloves. CNA JJ placed gloves in her pocket, closed the door and without sanitizing her hands placed gloves from her pocket and applied barrier cream on the resident's buttocks. CNA RR and CNA JJ completed perineal care and with the same soiled gloves on, touched the Resident's clean shirt, brief, sheet, and blanket. Both CNA JJ and CNA RR left the room without sanitizing or washing their hands. In an interview on 03/27/24 at 2:42p.m., with CNA RR, she said she did good assisting CNA JJ. She said CNA JJ should have changed her gloves, washed her hands, or used hand sanitizer before placing clean brief on. She said the failure placed the resident at risk for infections. In an interview on 03/27/24 at 2:44p.m., with CNA JJ, she said she had been working at the facility for the last 7 years as a full-time employee. CNA JJ said she did not spread Resident's labia and clean the resident's meatus during incontinent care because I was nervous. She said the failure placed the resident at risk for infections. She said she did not recall doing CNA competency checks for incontinent care. CNA JJ said she had performed hand hygiene during the delivery of incontinent care to Resident#24. CNA JJ said, I went across Resident#24's room and used the hand sanitizer that was sitting on the med cart. At this time the Surveyor shared her observation from earlier that the Surveyor did not observe her step out of Resident#24's room and observed CNA ZZ hand her packets of barrier cream and gloves. CNA JJ said her actions in not performing hand hygiene while changing gloves could result in cross contamination. She said she had completed in-service on infection control last month and could not recall the exact date. In an interview on 03/27/24 at 2:48p.m., with CNA ZZ, she said she handed CNA JJ a pair of gloves and barrier cream packets when she came to check if CNA JJ and RR needed her assistance during incontinent care. In an interview on 03/28/24 at 1:24 p.m., with the DON, she said she expected staff to make sure they provided complete and proper incontinent care. She said CNAs should have either washed or sanitized their hands after touching a dirty area prior to moving to a clean area when performing incontinent care. She said these failures were risk for infection control. She said staff received training/in-service on infection control often. She said CNAs were provided training and competency check offs quarterly and as needed. At this time policy on perineal care was requested. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Hand Hygiene policy (Revised 6/2019) revealed read in part: .It is the policy of this facility that proper hand hygiene/hand washing technique will be accomplished at all times that handwashing is indicated. Hand Hygiene/Hand washing is the most important component for preventing the spread of infection. Procedure: After: After removal of medical/surgical or utility gloves. NOTE: Wash hands at end of procedures where glove changes are not required. For procedures in which change of gloves, e.g., clean gloves to sterile gloves, is indicated follow the specific standard of practice. However, hand washing may not be necessary until completion of the procedure. If glove hands become contaminated as gloves are changed hands can be washed. Contact with a patient's/resident's intact skin (e.g. taking a pulse or blood pressure, performing physical examinations, lifting the patient/resident inn bed . Record review of the Infection Control Program (Revised 2/2022) revealed read in part: .Policy: Evidence-based policies and procedures are the foundation of a facility's infection control and prevention program. Goals: A Decrease the risk of infections and communicable diseases to residents, employees, volunteers, and visitors .