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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, record review and interview the facility failed to thoroughly investigate and report an incident for 1 (Resident #1) of 6 reviewed for abuse and neglect. The facility failed to report Neglect after Resident #1 drank hand sanitizer. The facility failed to thoroughly investigate after Resident #1 got a hold of a bottle of hand sanitizer and drank it and was hospitalized on [DATE]. This failure could have placed residents at risk of abuse and neglect. Findings included: Record review of Resident #1's face sheet revealed she was a [AGE] year-old female with diagnosis of Alzheimer Disease with late onset(a progressive disease that destroys memory and important mental functions), Type 2 Diabetes, Mellitus (a chronic disease in which the body has trouble controlling blood sugar) Acute kidney failure (a condition in which the kidneys cannot filter waste), and bi-polar disorder(a disorder associated with episodes of mood swings ranging from depressive lows and manic highs). Record review of Resident #1's MDS quarterly dated 12/25/2025 revealed BIMS Summary score of 03. Section E0900- Wandering Presence and Frequency was coded as O. Behavior not exhibited. Section P0200- Restraints and Alarms revealed E. Wander/Elopement alarm was used. Record review of Resident #1's care plan dated 11/20/2019 and target date of 2/21/2025 revealed: Focus: Resident #1 is at risk for elopement related to wandering. Resident requires a wander guard for safety. Goal: Patient was not to have no incidence of elopement. Interventions: check placement and function of wander guard, evaluate effect og cognitive impairment upon resident's ability to understand changes in surroundings. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: Resident #1 have little or no awareness of safety, or boundaries related to other's personal space. Going into other resident's rooms, not always aware if areas are okay for her to be in, rummaging through items that are not hers. Wandering about her living space. Resident #1 wander aimlessly into other residents' rooms. Staff redirects me. Date initiated 1/19/2025 revised on 2/20/2025. Goal: Resident #1 will be able to maintain a meaningful life. Interventions: If Resident #1 was wandering into other residents' rooms gently re-direct her by taking her hand and lead me into other parts of open space that offers me activities that may be engaging. Record review of elopement Risk evaluation dated 2/27/2025 revealed that Resident #1 was at risk for wandering due to her cognitive impairment and poor decision making. Record review of Resident #1's nursing progress note dated 3/17/2025 at 3:00pm, stated Resident #1 was found sipping ethyl alcohol 70% from a hand sanitizer container. The resident appeared alert. No immediate signs of distress were noted at the time of observation. Nurse immediately intervened and took the container from resident. Resident #1 was assessed for any signs of alcohol poisoning or adverse reactions, including vital signs and level of consciousness and any complaints of discomfort. The attending physician was notified. Resident #1 was monitored closely for any potential effects of alcohol poisoning. Poison Control was contacted, and a case number assigned. Nurse was told to continue to monitor. Record review of nursing progress note dated 3/17/2025 at 4:50pm, revealed that the receptionist called the charge nurse because Resident #1 was in the lobby and hard to awaken. Nurse stated that when she arrived at the scene, the resident was having shakes of upper extremities with her eyes opened. She was offered candy, and she asked, where was the candy?. Physician was contacted and vitals taken. Blood sugar was 201. Physician A stated to send her out to the ER. Record review of Resident #1's hospital record dated 3/17/2025 revealed chief complaint for visit was said to be drug overdose. Report stated resident #1 admitted with dementia unknown baseline who was found drinking hand sanitizer at the nursing home. EMS states unknown amount. Labs including etoh level ordered. Etoh (ethanol) wa negative. Resident #1 will require admission to the IMU for close monitoring. Lab ordered stat: Ethanol Level Value <5.0 Comment: The pharmacological responses to blood alcohol levels may vary from individual to individual. The fatal concentration had been reported to be greater than 400.0mg/dl. Ethanol % <0.005. Record review of in-service training revealed RN A had conducted an in-service on 3.17.2025 it covered: Identify and labeling of all hazardous material according to safety guidelines, ensuring all hazardous materials are stored properly in locked cabinets or areas inaccessible to residents, and if residents get hazardous material notify DON, Administrator, Physician, family and poison control. Record review of typed statements pertaining to the incident of Resident #1 drinking hand sanitizer were not signed. Further review of information provided by the Administrator were Resident #1's face sheet, medication review and care plan all had print dates of 4/1/2025 (exit date). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with RP on 3/31/2025 @ 12:28pm, stated that she had been called about the incident when Resident #1 drank hand sanitizer. She stated that she was told that the hand sanitizer came from one of the medication carts. She said she did not recall the name of the nurse that called her. She said Resident #1 did not have a history of seizures. She stated she was aware that she had been wandering at the facility and had a wander guard. She stated that wander guard was used so she would not leave out of the door. She walked in circles both day and night. She had late-stage Alzheimer disease. She had gone into other resident's rooms a few times. She had no history of leaving the building. She said she was not a fall risk. She stated that she had been told by hospital staff that the labs showed she had a small amount of the hand sanitizer in her system, not enough to harm her. An interview with RN A on 3/31/2025 at 3:48pm stated that she had been employed for two to three weeks, and worked the 8a-5pm shift M-F. She stated that she was the unit manager. She said the charge nurse (LVN A) told her that Resident #1 had drank hand sanitizer or at least that hand sanitizer was all over her shirt. She said she called Poison Control and was provided a case number. LVN A worked Hall 4 and was familiar with the residents' behavior. She stated when she spoke with the doctor, she was told to monitor and if her vitals changed to call him back. She said LVN A called the doctor the second time to let him know she was hard to awaken and that her blood sugar was higher than normal. She said drinking ethyl alcohol could have had the resident inebriated, or it could have gotten in her eyes and that would have been bad, death if someone were to drink a whole lot of it. She was not sure what sized bottle the resident had. She stated she had conducted an in-service on 3/17/2025 about patient safety and hazardous material storage. An interview on 3/31/2025 at 4:05pm, Physician A stated that he was notified about Resident #1 drinking the hand sanitizer. He said at the time no one told him how much. He said they called poison control, and they told the nurse to just monitor. He said when they called him back about her being hard to awaken, he told them to send her out to the hospital for precaution. He said hand sanitizer could affect the liver. He said the hospital said she did not have much and was not deemed harmful at least, he repeated her labs, and they were pretty good. It is unknown how much she drank. No long-term effects from it. Labs were not abnormal from drinking the hand sanitizer. She was at her baseline. He said the only recommendation for her wandering and seeking items that might be harmful is supervising her. He said they need to monitor her closely. He said everyone knows her. Everyone was watching out for her. He said she wander ed but mostly sit in the lobby. He said the key was monitoring her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LVNA on 4/1/2025 at 10:36am, she said she had been a nurse for [AGE] years. She had been an employee for about 6 months. She worked here from 2000-2005 and she just came back. She stated that CMA A alerted her that Resident #1 had drank hand sanitizer. She had it on her shirt. She talked with the unit manager (RN A); she called poison control and the doctor. She was told to monitoring her. She watched her for a change in condition. She said Resident #1 went to the front lobby to sit as she usually does then she was alerted by the receptionist that she could not awake her. She said the Resident had been in the lobby about 30-40 minutes. She said she took her vitals and blood sugar was out of baseline (200was not usually more than 140. She was taken to the room, and she called Physician A and he said to send her out 911. She said the hand sanitizer was usually in the locked cart. She was walking on the hall when CMA A saw Resident #1 with the bottle in her hand and it was on her chest. They assumed that she drank it. It looks like a brand-new bottle. No hand sanitizer was on her face, and she did not smell it on her breathe. When EMS arrived, she wanted to eat, and her tray was already on the tray table. She began to fight as she wanted to eat. She said she got a report from the DON that Resident #1';s sodium was high and no trace of the hand sanitizer from the blood test. Sodium level was 160 when she got to the hospital. She does have a diagnosis of renal disease. One intervention they put in place was to give her a bottled water. She walked around with it in her hand all day drinking along the way. An interview with Receptionist B on 4/1/2025 at 11:25am revealed she had been employed at the facility since January 2025. She normally worked from 3p-8p in the evening. She stated that Resident #1 normally sit in the front lobby and walk around too. She stated that she had been sitting there for 30-40 minutes on 3/17/2025. She attempted to wake her. Her eyes were opened but she was not responding. A CNA came they tried to get her up. She told the CNA to go get a nurse. LVN A came, and they got her in the chair, and she was taken to the station. They called 911 and she asked what happened because she not normally like that she normally walked a lot, sat in the lobby and then walked some more all day. She said to herself, something happened because that was not like her. She sometimes pass and get a candy from her desk. If she sat in the lobby too long, she would call the station and ask them to come get her. Interview with CMA A on 4/1/2025 at 11:56am, she said she had been employed 1.5 years and worked Hall 400 (where Resident #1) resided. She said on 3/17/2025 she saw Resident #1 coming from the back side of 400. She said the bottle of hand sanitizer was up against her mouth and turned upside down in the air (as someone drinking a beverage). She said she saw hand sanitizer on her shirt. She said that she immediately took the bottle, but Resident would not hand her the top. She said she called for the charge nurse (LVN A) to come to help her as the resident began to get aggressive with her. She said then the nurse took her into her room and took her vitals. She said as far as she was aware her vitals were normal. She said she was not aware that she was found in the lobby hard to awaken. She said she heard that later in the day. She said the hand sanitizer did not come from her medication cart as hers was still on the cart. She said the hand sanitizer was usually kept on top of the medication cart for use before passing medications. She said they had an in-service and now they must keep it inside of their carts. She said hand sanitizer is hazardous for anyone with dementia or with any ailments. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and Interview on 4/1/2025 at 12:12pm CMA B said she had been employed since October 2024. She worked 7a-7pm shift. She said she worked on Hall 300. She stated that she hid her hand sanitizer behind her pill crusher. Observation of a 2 oz. bottle of hand sanitizer on top of the medication cart near the pill crusher. She said she recall an in-service about keeping the hand sanitizer in the draw, but she needed to use it so often when passing medications, she just hid it. They usually have a big bottle that was kept in the side pocket on the cart. She said although there is hand sanitizer on the wall they are too far apart for her to use before passing medications. She sanitizer hands before and after passing medications. A telephone interview with the DON on 4//1/2025 at 2:25pm she stated no one saw Resident #1 drink the hand sanitizer to her knowledge. Then, she was told that she had a change in condition and got orders from physician A to send her out. The nurse reported to EMS that she was hard to arouse. She said hypernatremia was her diagnosis. She had been hydrated her with IV fluids and they monitored her labs when she returned. She said the hospital report indicated that she did not have any alcohol in her system. She said no staff admitted to giving Resident #1 the hand sanitizer. She said she did an investigation, and they immediately started an in-service immediately and made sure there was no hand sanitizer. What could have happened to her had she drunk the hand sanitizer- could cause disoriented, she is not sure about any amount of alcohol, impaired vision, and cognitive impairment or inebriated. She said she did not call in this incident to State agency due to the fact she was not harmed. An interview with the Administrator on 4/1/2025 at 3:04pm, revealed she had been employed since September 2023. She said she found out Resident #1 had drunk hand sanitizer during their in daily clinical morning meeting the next day. She said she talked to the DON after she interviewed staff and she said staff did not see her drink hand sanitizer. She said Resident #1 was in the lobby, and she was unresponsive. She was sent out to the hospital. She said she saw the hospital record today and it indicated that she had 0.005% ethyl alcohol in her system. When she talked to Physician A, he was not alarmed. They also did an ad hoc qapi with their medical director. She said it reconfirmed that the resident was accessed, and the nurse had immediately called the poison control. She said Resident #1 was not symptomatic. She said most staff use the dispensers affixed on the walls. She said she understood it was a small maybe 2 oz bottle, so there is not that much in the bottle. She said she was not a nurse or a doctor, so she did not know what could have happened if she had drunk more of the hand sanitizer. She said the nurse called poison control, and they took necessary measures. She said in the past she would often over report to State office as her reason for not reporting this incident. Record review of TULIP on 4/1/2025 revealed no incident was found. Record review of the facility's abuse, neglect policy, dated 1/2019, revealed the purpose was to prohibit and prevent abuse, neglect and exploitation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on interview, and record review the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good hygiene for 1 of 6 residents (Resident #2) reviewed for Activities of Daily Living. 1. Resident #2 had not been showered as scheduled on 3/10, 3/24, or 3/28/2025. These failures could place residents at risk of embarrassment, discomfort, and skin breakdown. Findings included: Record review Resident #2's face sheet revealed he was a [AGE] year-old male that was admitted to the facility on [DATE] with chronic obstructive pulmonary disease(lung disease that block airflow and make it difficult to breathe), unspecified sequelae of cerebral infarction(another term for stroke), Type 2 diabetes mellitus(a chronic disease in which the body has trouble controlling blood sugar), hemiplegia and hemiparesis (partial paralysis on one side of the body), and muscle weakness (decreased strength in the muscles). Record review Resident #2 quarterly MDS date 1/7/2025 revealed Section C-0500- BIM summary score of 12 which meant he had moderate cognitive impairment. Section GG-0115- functionality limitation in range of motion revealed Resident #2 had impairment on one side both upper and lower extremities. Section GG- Mobility devices revealed a wheelchair was used for mobility. Section GG0130- E. Shower/bathe was coded as 02-which meant substantial/maximal assistance - helper does more than half the effort. Record review of Resident #2's care plan dated 12/20/2024 revised on 2/18/2025 revealed the resident has an ADL self-care performance deficit r/t activity intolerance, limited mobility. Goal: The resident will maintain current level of function through the review date. Interventions: Body odor prefers to use Arm and Hammer. Encourage the resident to participate to the fullest extent possible with each interaction. Monitor /document report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Resident #2's plan of care revealed Resident #2 shower days were on Mondays, Wednesdays and Fridays on the 6a-2pm shift. Review of care staff plan of care revealed there were no documentation of showers for Resident #2 on 3/10/2025 (M), 3/24/2025(M) and 3/28/2025(F) when his shower days were scheduled on Mondays, Wednesdays and Fridays. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident #2 on 3/29/2025 at 10:09am, revealed him to state thatthat the resident he does not refuse showers. He stated that if staff said he refused showers they were not telling the truth. He stated he was often told by the CNAs that they are short because of call ins. He said his shower days were on Mondays, Wednesdays, and Fridays. He said he had not denied showers. He said he would not because he enjoyed have a clean body. He said staff told him the next shift would do his shower. He said he preferred showers before lunch. During an interview with CNA C on 3/29/2025 at 10:21am, she said she had been employed for [AGE] years. She said she worked stations 1 and 2(located on Halls 100 and 200) on first shift (6a-2pm). She said Resident #2 had not refused showers with her. She stated that she always got her showers completed. CNA A said sometimes the CMAs, or the nurse helps with other things so she could shower residents. She stated that she input all ADLs assisted with in PCC from the kiosk on the wall. She stated she would tell the charge nurse if Resident #2 refused showers. During an interview with RN B on 3/29/2025 at 11:08am, she said she had been employed here for 9 1/2 years. She said she worked the 10am-6pm. She normally worked Station 1 (Hall 100). She stated Resident #2 had not refused showers as far as she was aware. She stated she assisted with showers sometimes. She stated when she assisted with showers, she also did her skin checks. She said when a resident missed a shower, they would not have good hygiene, could get infections and that would not be a good thing. A telephone interview with the DON on 4/1/2025 at 2:25pm she said she had been off from the facility since 3/25/2025. She said prior to her leave, she required staff bring her daily shower sheets at the end of the shift. But CNAs are supposed to let their nurse know if there were refusals as soon as possible. She said she had received some complaints about residents not getting showers. She said anytime she received this as a complaint she would check with staff about why residents did not get their shower. She said if showers are refused, they are care planned for refusals of ADLs. She said even if a resident refused on one shift, they would sometimes allow a different staff or next shift to shower them. She said she could not recall if Resident #2 had refused showers. She said if a resident does not get showers as scheduled, this could cause body odor, embarrassment, and infections. An interview with the Administrator on 4/1/2025 at 3:04pm, she said she had been employed at the facility since September 2023. She stated that she was not aware of residents were not getting showers. She said the DON typically have a schedule in place and they are supposed to follow-up with the CNAs if they do not complate any of the Resident ADLs. She said she would bring the shower schedule for Resident #2. She stated if a resident does not get a shower as scheduled, they could have bad hygiene.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 was adequately supervised as a result she drank hand sanitizer and was hospitalized from 3/17/2025-3/20/2025. This failure could place residents at risk of severe injuries, require hospitalization , or death due to lack of supervision by facility staff. Findings iIncluded: Record review of Resident #1's face sheet revealed she was a [AGE] year-old female with diagnosis of Alzheimer Disease with late onset (a progressive disease that destroys memory and important mental functions), Type 2 Diabetes, Mellitus (a chronic disease in which the body has trouble controlling blood sugar) Acute kidney failure (a condition in which the kidneys cannot filter waste), and bpolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows and manic highs). Record review of Resident #1's MDS quarterly dated 12/25/2025 revealed BIMS Summary score of 03. Section E0900- Wandering Presence and Frequency was coded as O. Behavior not exhibited. Section P0200- Restraints and Alarms revealed E. Wander/Elopement alarm was used. Record review of Resident #1's care plan dated 11/20/2019 and target date of 2/21/2025 revealed: Focus: Resident #1 was at risk for elopement related to wandering. Resident requires a wander guard for safety. Goal: Patient was not to have no incidence of elopement. Interventions: check placement and function of wander guard, evaluate effect of cognitive impairment upon resident's ability to understand changes in surroundings. Focus: Resident #1 have little or no awareness of safety, or boundaries related to other's personal space. Going into other resident's rooms, not always aware if areas are okay for her to be in, rummaging through items that are not hers. Wandering about her living space. I wander aimlessly into other residents' rooms. Staff redirects me. Date initiated 1/19/2025 revised on 2/20/2025. Goal: Resident #1 will be able to maintain a meaningful life. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions: If Resident #1 was wandering into other residents' rooms gently re-direct her by taking her hand and lead me into other parts of open space that offers me activities that may be engaging. Record review of elopement Risk evaluation dated 2/27/2025 revealed that Resident #1 was at risk for wandering due to her cognitive impairment and poor decision making. Record review of Resident #1's nursing progress note dated 3/17/2025 at 3:00pm, stated Resident #1 was found sipping ethyl alcohol 70% from a hand sanitizer container. The resident appeared alert. No immediate signs of distress were noted at the time of observation. Nurse immediately intervened and took the container from resident. Resident #1 was assessed fr any signs of alcohol poisoning or adverse reactions, including vital signs and level of consciousness and any complaints of discomfort. The attending physician was notified. Resident #1 was monitored closely for any potential effects of alcohol poisoning. Poison Control was contacted, and a case number assigned. Nurse was told to continue to monitor. Record review of nursing progress note dated 3/17/2025 at 4:50pm, revealed that the receptionist called the charge nurse because Resident #1 was in the lobby and hard to awaken. Nurse stated that when she arrived at the scene, the resident was having the shakes of upper extremities with her eyes opened. She was offered candy, and she asked, where was the candy?. Physician was contacted and vitals taken. Blood sugar was 201. Physician A stated to send her out to the ER. Record review of Resident #1's hospital record dated 3/17/2025 revealed chief complaint for visit was said to be drug overdose. Report stated resident #1 admitted with dementia unknown baseline who was found drinking hand sanitizer at the nursing home. EMS states unknown amount. Labs including etoh level ordered. Etoh (ethanol) is negative. Resident #1 will require admission to the IMU for close monitoring. Lab ordered stat: Ethanol Level Value <5.0 Comment: The pharmacological responses to blood alcohol levels may vary from individual to individual. The fatal concentration has been reported to be greater than 400.0mg/dl. Ethanol % <0.005 An interview with RP on 3/31/2025 @ 12:28pm, stated that she had been called about the incident when Resident #1 drank hand sanitizer. She stated that she was told that the hand sanitizer came from one of the medication carts. She said she did not recall the name of the nurse that called her. She said Resident #1 did not have a history of seizures. She stated she was aware that she had been wandering at the facility and had a wander guard. She stated that wander guard was used so she would not leave out of the door. She walked in circles both day and night. She had late-stage Alzheimer disease. She had gone into other resident's rooms a few times. She had no history of leaving the building. She said she was not a fall risk. She stated that she had been told by hospital staff that the labs showed she had a small amount of the hand sanitizer in her system, not enough to harm her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455682	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with RN A on 3/31/2025 at 3:48pm stated that she had been employed for two to three weeks, and worked the 8a-5pm shift M-F. She stated that she was the unit manager. She said the charge nurse (LVN A) told her that Resident #1 had drank hand sanitizer or at least that hand sanitizer was all over her shirt. She said she called Poison Control and was provided a case number. LVN A worked Hall 4 and was familiar with the residents' behavior. She stated when she spoke with the doctor, she was told to monitor and if her vitals changed to call him back. She said LVN A called the doctor the second time to let him know she was hard to awaken and that her blood sugar was higher than normal. She said drinking ethyl alcohol could have had the resident inebriated, or it could have gotten in her eyes and that would have been bad, death if someone were to drink a whole lot of it. She was not sure what sized bottle the resident had. She stated she had conducted an in-service on 3/17/2025 about patient safety and hazardous material storage. An interview on 3/31/2025 at 4:05pm, Physician A stated that he was notified about Resident #1 drinking the hand sanitizer. He said at the time no one told him how much. He said they called poison control, and they told the nurse to just monitor. He said when they called him back about her being hard to awaken, he told them to send her out to the hospital for precaution. He said hand sanitizer could affect the liver. He said the hospital said she did not have much and was not deemed harmful at least, he repeated her labs, and they were pretty good. It is unknown how much she drank. No long-term effects from it. Labs were not abnormal from drinking the hand sanitizer. She was at her baseline. He said the only recommendation for her wandering and seeking items that might be harmful was supervising her. He said they need to monitor her closely. He said everyone knows her. Everyone was watching out for her. He said she wandered but mostly sit in the lobby. He said the key was monitoring her. An interview with LVNA on 4/1/2025 at 10:36am, she said she had been a nurse for [AGE] years. She had been an employee for about 6 months. She worked here from 2000-2005 and she just came back. She stated that CMA A alerted her that Resident #1 had drank hand sanitizer. She had it on her shirt. She talked with the unit manager (RN A); she called poison control and the doctor. She was told to monitoring her. She watched her for a change in condition. She said Resident #1 went to the front lobby to sit as she usually does then she was alerted by the receptionist that she could not awake her. She said the Resident had been in the lobby about 30-40 minutes. She said she took her vitals and blood sugar was out of baseline (200) it is not usually more than 140. She was taken to the room, and she called Physician A and he said to send her out 911. She said the hand sanitizer is usually in the locked cart. She was walking on the hall when CMA A saw Resident #1 with the bottle in her hand and it was on her chest. They assumed that she drank it. It looks like a brand-new bottle. No hand sanitizer was on her face, and she did not smell it on her breathe. When EMS arrived, she wanted to eat, and her tray was already on the tray table. She began to fight as she wanted to eat. She said she got a report from the DON that Resident #1'; s sodium was high and no trace of the hand sanitizer from the blood test. Sodium level was 160 when she got to the hospital. She does have a diagnosis of renal disease. One intervention they put in place was to give her a bottled water. She walked around with it in her hand all day drinking along the way. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with receptionist B on 4/1/2025 at 11:25am revealed she had been employed at the facility since January 2025. She normally worked from 3p-8p in the evening. She stated that Resident #1 normally sit in the front lobby and walk around too. She stated that she had been sitting there for 30-40 minutes on 3/17/2025. She attempted to wake her. Her eyes were opened but she was not responding. A CNA came they tried to get her up. She told the CNA to go get a nurse. LVN A came, and they got her in the chair, and she was taken to the station. They called 911 and she asked what happened because she not normally like that she normally walked a lot, sat in the lobby and then walked some more all day. She said to herself, something happened because that was not like her. She sometimes passed and got a candy from her desk. If she sat in the lobby too long, she would call the station and ask them to come get her. Interview with CMA A on 4/1/2025 at 11:56am, she said she had been employed 1.5 years and worked Hall 400 (where Resident #1) resided. She said on 3/17/2025 she saw Resident #1 coming from the back side of 400. She said the bottle of hand sanitizer was up against her mouth and turned upside down in the air (as someone drinking a beverage). She said she saw hand sanitizer on her shirt. She said that she immediately took the bottle, but Resident would not hand her the top. She said she called for the charge nurse (LVN A) to come to help her as the resident began to get aggressive with her. She said then the nurse took her into her room and took her vitals. She said as far as she was aware her vitals were normal. She said she was not aware that she was found in the lobby hard to awaken. She said she heard that later in the day. She said the hand sanitizer did not come from her medication cart as hers was still on the cart. She said the hand sanitizer was usually kept on top of the medication cart for use before passing medications. She said they had an in-service and now they must keep it inside of their carts. She said hand sanitizer is hazardous for anyone with dementia or with any ailments. Observation and Interview on 4/1/2025 at 12:12pm CMA B said she had been employed since October 2024. She worked 7a-7pm shift. She said she worked on Hall 300. She stated that she hid her hand sanitizer behind her pill crusher. Observation of a 2 oz. bottle of hand sanitizer on top of the medication cart near the pill crusher. She said she recall an in-service about keeping the hand sanitizer in the draw, but she needed to use it so often when passing medications, she just hid it. They usually have a big bottle that was kept in the side pocket on the cart. She said although there was hand sanitizer on the wall they are too far apart for her to use before passing medications. She said she did sanitizer hands before and after passing medications. An interview on 4/1/2025 at 12:25pm with Interview with NP state that he had been fat the facility for about 2 years. He stated that he had about 90 residents at the facility. He stated that Resident #1 have had recent medications changed due to the pacing/wandering. He stated that Resident #1 had bi-polar and late-stage Dementia and was on a low dosage of Zyprexa. He said a recent GDR was done for her to help with the anxiety and pacing. He stated he had not been informed about her drinking hand sanitizer. He said that if any resident drinks enough hand sanitizer it could be harmful. He said he could not speak on outcomes because he would need all the details. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A telephone interview with the DON on 4//1/2025 at 2:25pm she stated no one saw Resident #1 drink the hand sanitizer to her knowledge. Then, she was told that she had a change in condition and got orders from physician A to send her out. The nurse reported to EMS that she was hard to arouse. She said hypernatremia was her diagnosis. She had been hydrated her with IV fluids and they monitored her labs when she returned. She said the hospital report indicated that she did not have any alcohol in her system. She said no staff admitted to giving Resident #1 the hand sanitizer. She did an investigation, and they immediately started an in-service immediately and made sure there was no hand sanitizer. What could have happened to her had she drunk the hand sanitizer- could cause disoriented, she is not sure about any amount of alcohol, impaired vision and cognitive impairment or inebriated. An interview with the Administrator on 4/1/2025 at 3:04pm, revealed she had been employed since September 2023. She said she found out Resident #1 had drunk hand sanitizer during their in daily clinical morning meeting the next day. She said she talked to the DON after she interviewed staff, and she said staff did not see her drink hand sanitizer. She was in the lobby, and she was unresponsive. She was sent out to the hospital. She said she saw the hospital record today and it indicated that she had 0.005% ethyl alcohol in her system. When she talked to Physician A, he was not alarmed. They also did an ad hoc qapi with their medical director. She said it reconfirmed that the resident was accessed, and the nurse had immediately called the poison control. She said Resident #1 was not symptomaticnot symptomatic. She said they never found out where the resident got the hand sanitizer. She said most staff use the dispensers affixed on the walls. She said she understood it was a small maybe 2 oz bottle, so there was not that much in the bottle. She said she was not a nurse or a doctor, so she did not know what could have happened if she had drunk more of the hand sanitizer. She said the nurse called poison control, and they took necessary measures. She said the verbal report from the DON was that she had no alcohol in her system. She said the hospital records showed that alcohol was negative. She said the DON also did in-services with staff and she will provide a copy of the in-service. A copy of the facility's Accident and supervision policy for review was requested but not received prior to exit.