

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Kirkwood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2590 Loop 337 N New Braunfels, TX 78130	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27520</p> <p>39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the resident received care and services safely and the physical layout of the facility maximized resident independence and did not pose a safety risk; provided maintenance services necessary to maintain an orderly, and comfortable interior; provide adequate and comfortable lighting levels in all areas; for 2 of 2 shower rooms (600 hall shower on E and W side), maintained shower free of safety hazards for 1 of 2 Showers (600 Hall Shower), and 1 of 1 Resident's room (Resident #68) reviewed for safety hazards.</p> <ol style="list-style-type: none"> <li>1. The water temperature in the 600 E shower room reached 95.5 degrees and the water temperature in the W shower room reached 97.1 degrees. The safe water temperature range should be 100 to 110 degrees.</li> <li>2. There was a long hole on a wall around an electrical outlet beside Resident #68's bed.</li> <li>3. There was broken tiles in the 600 E shower room for at least a couple of months.</li> </ol> <p>These failures could place residents at risk of living in an uncomfortable and unsafe environment; exposing them to possible electrical hazards and resulting in decreased feelings of self-worth, and a diminished quality of life.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Observation and interview on 02/18/25 at 02:17 PM revealed Resident ##121 was sitting in bed. He expressed being upset because he could not take a shower. He stated there was no hot water. He stated he did not get a shower the week before on Thursday (2/13/25), Saturday (2/15/25) and then again today. Resident #121 stated nursing staff offered him a bed bath on Saturday but he preferred a hot shower. He stated it had been an on-going issue for at least a couple of weeks.</li> </ol> <p>Observation and interview on 02/18/25 at 03:10 PM revealed ADON L running the hot water in the 600 E shower stall. The ADON ran the hot water several minutes. The ADON stated the water temperature felt luke warm to the hand.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 2/18/25 at 3:20 with ADON L in the 600 W shower room revealed she ran the hot water in the shower stall for several minutes. She stated the water temperature was luke warm to the hand. ADON L stated she knew some of the residents liked he water hotter during showers.</p> <p>Interview on 2/18/25 at 3:35 PM with the ADM revealed they had a problem with the hot water a couple of months ago and he had a plumbing company come out. They replaced the mixing valve on the water heater which serviced the 600 hallway. He stated this was the result after Resident #121 complained the water temperature was cold in the shower.</p> <p>Observation and interview on 2/18/25 at 4:20 PM revealed the ADM running the hot water in the 600 E shower stall. He collected water in a plastic cup and took the temperature with a thermometer. He ran the hot water for about 3 to 5 minutes. The ADM stated the temperature was 94.3. The ADM then took the temperature of the water at the sink. He stated the temperature was 95.5. The ADM stated he was not sure what the safe range was for the water temperature.</p> <p>Observation and interview on 2/18/25 at 4:27 PM revealed the ADM and MS M from a sister facility took the temperature of the water in the 600 W shower stall collecting the water in plastic cup. The MS stated the water temperature was 96. He then took the temperature at the sink and stated it was 97.1. The MS stated the safe range for the water temp in Texas was 100 to 110 degrees.</p> <p>Interview on 02/20/25 at 4:35 PM with CNA J revealed she worked on the 600 hall regularly. She stated Resident #121, Resident #129, and Resident #130 had complained about cold water in the shower. CNA J stated they liked the water very hot water during showers and refused to shower when the water was luke warm. She stated the water had been luke warm off and on for about 4 to 6 weeks after the MS made some adjustments on the water heater. CNA J stated administrative staff stated they adjusted the temperature in order to stay in compliance with city or state guidelines. She stated about the only time the water was very hot was first thing in the morning otherwise it was luke warm especially after providing multiple showers. CNA J stated she would offer Resident #121, #129 and #130 a shower in the morning.</p> <p>Telephone interview on 02/21/25 at 10:36 AM with the facility MS revealed a plumbing company replaced the mixing valve on the water heater which serviced the 600 hall about a couple of months ago. He stated he set the temperature at 110 degrees. He stated last week there was a complaint about cold water in the shower, so he adjusted it and set it just a bit higher to avoid scalding water temperatures. The MS stated they checked water temperatures weekly and usually about mid-day. He stated the water temperatures had been within safe range which was 100 to 110 degrees.</p> <p>2. Record review of Resident #68's face sheet, dated 02/21/2025, revealed the resident was [AGE] years old female and admitted to the facility on [DATE] with cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), difficulty in walking, hypertension (high blood pressure), muscle weakness, and atherosclerotic heart disease of coronary artery without angina pectoris (involves plaque buildup in artery walls).</p> <p>Record review of Resident #68's quarterly MDS, dated [DATE], revealed Resident #68's BIMS score was 14 out of 15 that indicated the resident's cognition was intact, and the resident was independent (Residents completes the activity by themselves with no assistance from a helper) to sit to lying, lying to sitting on side of bed, and chair-to-bed transfer, but required substantial/maximal assistance (Helper does more than half the effort) to toilet transfer.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 02/18/2025 at 10:04 a.m. revealed there was an electronic outlet to the wall beside Resident #68's bed, and around the electronic outlet, there was a hole (length was about 12 cm, and the width was about 8 cm).</p> <p>Interview on 02/18/2025 at 11:20 a.m. with Resident #68 stated that the resident did not know the electronic outlet had a hole and did not use the electronic outlet. However, the resident stated it should have been fixed to prevent possible danger.</p> <p>Interview on 02/18/2025 at 11:12 a.m. with LVN-C stated there was a long hole to a wall around an electric outlet beside Resident #68's bed, nobody reported it to nurses, and it might cause electronic danger if Resident #68 touched the hole or put something inside the hole.</p> <p>In an interview on 02/21/2025 at 12:14 p.m. the Administrator said there was a long hole to a wall around an electric outlet beside Resident #68's bed, the facility did not know about the hole, and it was not good and not safe. The facility maintenance already left the building due to private reason, so the Administrator said he would contact the maintenance staff and let them fix it.</p> <p>Record review of the facility policy, titled Quality of Life - Safety, Resident, revised on 09/2016, revealed It is the policy of this facility to create a safe environment for the resident. 4. Avoid leaving in the resident's room any medication or equipment that might cause harm.</p> <p>It is the policy of this facility to ensure the resident environment remains as free of accident hazards as possible.</p> <p>PROCEDURES:</p> <ol style="list-style-type: none"> <li>1. Let the hot water run from the faucet for 3 to 5 min.</li> <li>2. Insert the stem into the stream of running water, so that the sensor is fully immersed. Some thermometer probes have a sensor in the tip and others have it from tip up to about 2 inches up the probe. The temperature should register in about 10 to 15 seconds.</li> <li>3. Test the water at various locations throughout your facility. with these areas being of primary focus             <ol style="list-style-type: none"> <li>a. Patient rooms, common areas, shower rooms, and Nurses station water temperatures are between &gt; 100 and &lt;110 Fahrenheit.</li> </ol> </li> </ol> <p>3. Observation and interview on 02/20/25 at 4:35 PM with CNA J while in the 600 E hall shower room revealed broken tiles on the bottom on both sides of the door enclosure next to the shower stall. CNA J stated she had seen the broken tiles months ago and stated it could cause skin tears or more serious skin injuries. She stated she had not reported it to maintenance but understood she could enter a work order for the MS on an electronic communication program so he would be aware and address the issue. CNA J stated she had not said anything to her nurse either but could have done that too. She stated it was important to report the broken tiles to ensure residents were not injured.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 2/20/25 at 4:55 PM with LVN K on the 600 E hall shower room revealed she knew of the broken tiles in the shower room along the door frame of the sitting area next to the shower stall. She stated she had seen the broken tiles weeks ago when making rounds and when she entered the shower room. LVN K stated residents could sustain skin tears or more serious skin injuries if they rubbed up against the broken tiles. LVN K stated she should have reported it to the MS but knew the MS made his own rounds. She stated she believed the MS knew about the problem.</p> <p>Telephone interview on 2/20/25 on 2/21/25 at 10:36 AM with the MS revealed he and his assistant completed safety checks of the building weekly including the shower rooms. He stated he noticed the broken tiles in the 600 E shower room some weeks back, but understood it would be addressed during the facility refresh. He stated a contractor would be making some renovations and the shower rooms were included in the plan. The MS stated he did not consider the safety risks at the time but stated it could cause skin cuts and it was not the place you want to get a cut because of infection control. He stated staff had not sent a work order through the facility computer program but stated he knew about the broken tiles and should have addressed it right away.</p> <p>Review of facility Policy and Procedure, Facility Maintenance, revised on 5/2022, read in relevant part: It is the policy of this facility to establish procedures for routine and non-routine care of the facility /building to ensure that the facility remains in good working order for resident and staff safety. 1. The facility utilizes the [name] program that tracks and maintains documentation for Preventative Maintenance and Regulator Tasks. Work Orders: 1. All work order requests must be in the form of work orders, not verbal (unless emergency situations). 2. The facility uses electronic work orders through [name].</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622</b></p> <p>Based on record reviews and interviews, the facility failed to ensure each PASRR Level 1 Screening done for each resident was correct for mental illness for 1 of 2 residents'(Resident #10) PASRRs reviewed, in that:</p> <p>Resident #10 had a PASRR Level 1 screening that did not indicate that she had a mental illness with a diagnosis of bipolar disorder and, the facility did not have Resident #10 screened again for possible services.</p> <p>This failure could cause the residents not to receive services needed to maintain the highest functional ability for their quality of life.</p> <p>The findings included:</p> <p>Record review of Resident # 10's face sheet dated 02/20/2025 revealed an [AGE] year old female admitted to the facility on [DATE] with diagnoses that included: CHF (congestive heart failure- a condition which the heart does not pump blood as well as it should), anxiety disorder, dementia, and bipolar disorder.</p> <p>Record review on of Resident # 10's Care Plan dated 11/06/2024 revealed Resident #10 was care planned for bipolar disorder with the use of an anti-psychotic medication.</p> <p>Record review on of Resident # 10's physician orders dated 11/14/2024 revealed the resident had an order for risperdal 1mg(milligram) at bedtime for mania.</p> <p>Record review on 2/20/2025 of Resident # 10's Quarterly MDS dated [DATE] revealed Resident # 10 had a BIMS score of 15 which was indicative of her cognition was intact.</p> <p>During an interview on 2/21/2025 at 9:30AM the SW said she started at the facility at the end of November 2024. She said for new admissions, the AC would usually helped and she was not sure if residents with mental illness were screened for PASRR services. The SW said she would ask the Administrator for an answer for residents with a mental illness diagnosis.</p> <p>During an interview on 2/21/2025 at 9:40AM the Administrator said he was not sure of the answer for residents with a mental illness diagnosis on whether they should be screened for PASRR services. He said the MDS Coordinator, and the AC (Admissions Coordinator) could be of better help for the answer.</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/21/2025 at 10:25AM the AC said when the facility received a PASRR from the hospital, the resident would be referred for services if it was positive and it would be uploaded in Point Click Care with the resident's records but was not sure if residents with mental illness should be screened for a Level II. She said the process would be when a positive PASRR was received it would be sent to the Social Worker to refer to the agency for Level II screening. The AC said they did not check to see if PASRR was correct and compare to the admitting resident's diagnosis to ensure if they were coded correctly. The DBD said unless a resident would be admitted from the community, that would be when the facility would do a PASRR Level 1 screening. The AC said they would now initiate the step of verifying the accuracy of the PASRRs for new admissions to ensure the residents received the services they need if eligible.</p> <p>During an interview on 2/21/2025 at 11:00AM the SW said PASRRs should be done correctly to ensure residents who were positive received the services they need. She said she realized now that the PASRRs on admission should be checked for accuracy and if done incorrectly, they need to be done correctly in correlation to the residents' diagnosis.</p> <p>Facility policy titled Resident Assessment and Associated Process dated 12/2023 stated: It is the policy of this facility that residents will be assessed and the finding documented in their clinical health record. Under Comprehensive Assessment stated: 5. Assessment information will be used to develop, review and revise the resident's comprehensive care plan. When applicable, recommendations from the pre-admission screening and resident review (PASRR) evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46677</p> <p>Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments person-centered care plan to reflect the current condition for 1 of 8 residents (Resident #110) reviewed for care plan revisions.</p> <p>1. The facility failed to ensure Resident #110's care plan was revised to reflect order to release seatbelt and harness on wheelchair every 2 hours for 10 minutes.</p> <p>This deficient practice could place resident at risk of not receiving appropriate interventions to meet their current needs.</p> <p>The findings included:</p> <p>Record review of Resident #110's face sheet, dated 02/19/2025, revealed the resident was a [AGE] year old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #110 had diagnostics of abnormal posture, unspecified intellectual disabilities, and cerebral palsy.</p> <p>Record review of Resident #110's MDS, dated [DATE], revealed her BIMS was unidentified. Section GG (Functional Ability) of the MDS stated the resident used a wheelchair. Section P (Restraints and Alarms) of the MDS stated resident used trunk restraint while in chair.</p> <p>Record review of Resident #110's consent for physical restraint identified residents need for seatbelt and harness while in wheelchair and was signed on 08/31/2023 by the resident's representative.</p> <p>Record review of Resident #110's order summary, dated 02/20/2025 revealed an order to release seatbelt and harness every 2 hours for 10 minutes for skin integrity, dated 01/09/2025.</p> <p>Record review of Resident #110's comprehensive care plan, printed 02/20/2025, revealed Physical restraint use seatbelt and harness to maintain posture while in wheelchair related to spastic quadriplegic cerebral palsy, epilepsy, intellectual disabilities per family preference with interventions to include Release seatbelt and harness every 4hrs for 10 minutes for skin integrity.</p> <p>Interview with Resident #110's representative on 02/19/2025 at 9:39 AM revealed Resident #110 utilizes a seatbelt and chest harness while in her wheelchair. The representative stated the facility reviewed consent for the seatbelt and chest harness and they were to be released a few times during each shift but could not remember the time frame.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LVN E on 02/20/2025 at 1:05 PM revealed Resident #110 utilized seatbelt and chest harness while in her wheelchair. LVN E stated Resident #110 was placed in her bed every two hours to have her brief changed and the seatbelt and harness were released at that time. LVN E was not aware how often the seatbelt and harness were ordered to be released. LVN E stated releasing the seatbelt and harness would release pressure on Resident #110. LVN E was unaware what the comprehensive person-centered care plan stated for Resident #110's seatbelt and harness.</p> <p>Interview with CNA B on 02/20/2025 at 1:17 PM revealed Resident #110 received frequent changes and was placed in bed every two hours to have her brief changed. CNA B stated Resident #110 utilized a seatbelt and harness only while in her wheelchair and was released when resident was transferred to her bed. CNA B was not aware that orders stated Resident #110's seatbelt and harness were to be released every 2 hours. CNA B was also unaware that comprehensive person-centered care plan stated for Resident #110's seatbelt and harness were to be released every 4 hours.</p> <p>Interview with DON on 02/20/2025 at 1:27 PM revealed Resident #110 utilized the seatbelt and harness while in the wheelchair. The DON stated the harness and seatbelt were utilized for the resident's safety since she was unable to support herself while sitting. DON stated that Resident #110 should have her seatbelt and harness released according to the orders. DON stated Resident #110's care plan should reflect the most recent orders. The DON confirmed the orders dated 01/09/2025 stated the seatbelt and harness were to be released every two hours for 10 minutes while the current care plan stated seatbelt and harness were to be released every 4 hours for 10 minutes. DON stated it was important that care plans and orders match to ensure continuity of services. The DON did not identify person responsible to revise care plans.</p> <p>Record review of facility policy Comprehensive Person-Centered Care Planning revision dated 12/2023, revealed 6. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27520</p> <p>Based on observation, interview and record review revealed the facility failed to ensure the resident environment remained was free of accident hazards as is possible in residents received adequate supervision and assistance devices to prevent accidents for 1 of 6 Residents (Resident #187) observed for safety hazards.</p> <p>1. Nursing staff failed to put down a floor mat used as a preventative device on the right side of Resident #187's bed.</p> <p>This deficient practices could affect any resident and could contribute to avoidable falls and accidents.</p> <p>The findings were:</p> <p>1. Review of Resident #187's face sheet, dated 2/20/25, revealed she was admitted to the facility on [DATE] with diagnosis including unspecified Dementia.</p> <p>Review of Resident #187's Care Plan, dated 2/15/25, revealed she was a fall risk and some of the interventions included bed in lowest position and floor mats at bedside.</p> <p>Review of Resident #187's Fall Risk Evaluation, dated 2/15/25, revealed she was a high risk for falling related to disoriented x 2 and had 1 to 2 falls in past in past 3 months.</p> <p>Review of Resident #187's physician orders for February 2025 revealed an order: Fall Mat- Check Placement x 1 on R side every shift, Phone Active 02/17/2025.</p> <p>Observation and interview on 2/21/25 at 4:55 PM revealed Resident #187 lying in bed sleeping. There was not a floor mat on either side of the bed.</p> <p>Observation and interview on 2/21/25 at 5:00 PM revealed Resident #187 lying in bed sleeping. There was not a floor mat on either side of the bed. Interview with LVN K revealed Resident #187 was a fall risk and should have a mat in place. She stated they decided not to use a fall mat on the side closest to the bathroom because Resident #187 would get out of bed and would ambulate, but there should be one on the right side. LVN K stated Resident #187 had a history of falling and was very confused. She stated the mat was used as a safety precaution in the event she rolled out of bed, it would prevent injuries.</p> <p>Telephone interview on 02/21/25 at 12:20 PM with the DON revealed he was not as familiar with Resident #187 because she was a new admission. The DON stated upon reviewing Resident #187's Electronic Health Record (EHR) revealed an entry for the use of a fall mat. He stated fall mats were used as an intervention to minimize the risk of injury. He stated a physician order was not necessary but used more as a reminder for nursing staff to use the mat/intervention to help keep Resident #187 safe. The DON stated it was important nursing staff applied the mat for this reason; to maintain resident safety.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bowel and bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #70) reviewed for incontinence care.</p> <p>When CNA-D was providing incontinent care to Resident #70 on 02/20/2025, CNA-D did not separate the resident's labia and did not clean the base of her labia. Then, CNA-D turned the resident to her left side and started cleaning the resident's bowel movement. However, the CNA-D did not clean Resident #70's bowel movement completely.</p> <p>This failure could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections.</p> <p>The findings included:</p> <p>Record review of Resident #70's face sheet, dated 02/18/2025, revealed a [AGE] year-old female and admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease of coronary artery without angina pectoris (involves plaque buildup in artery walls), transient ischemic attack (short period of symptoms similar to those of a stroke), hypertension (high blood pressure), pulmonary fibrosis (a disease where there is scarring of the lung which makes it difficult to breathe), and gastro esophageal reflux disease (stomach acid or bile irritates the food pipe lining).</p> <p>Record review of Resident #70's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 13 out of 15 and indicated the resident's cognition was intact, the resident always had bowel and bladder incontinence, and required partial/moderate assistance (helper does less than half the effort) to chair-to-bed and shower transfer.</p> <p>Record review of Resident #70's comprehensive care plan, dated 09/04/2024, revealed the resident had bowel and bladder incontinence related to impaired mobility - Monitor/document for signs and symptoms of urinary tract infection.</p> <p>Observation on 02/20/2025 at 11:42 a.m. revealed CNA-D cleaned Resident #70's left and right groin area, then just cleaned the middle one of the resident's genital areas without separating the resident's labia area. Further observation revealed CNA-D turned the resident to her left side and cleaned the resident's bottom area because the resident had a bowel movement. CNA-D swept two times, the resident's bottom area with cleaning wipes to remove the bowel movement, then put a new and clean brief after sanitizing CNA-D's hands to the resident. The state surveyor said, Could you please sweep one more time to make sure cleaning all bowel movement? When CNA-D swept the resident's anal area, the bowel movement was still on the resident's anal area. CNA-D re-started cleaning the bowel movement, cleaned the bowel movement completely after sweeping the resident's anal area several times.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Kirkwood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2590 Loop 337 N New Braunfels, TX 78130	

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/20/2025 at 11:49 a.m. CNA-D stated she did not separate Resident #70's labia area and did not clean the base of the resident's labia area. Further interview with the CNA-D said she did not completely clean the resident's bowel movement. CNA-D stated she thought two times of sweeping were enough to remove all bowel movement, and she forgot separating the resident's labia area to clean the base of labia because she was so nervous. CNA-D stated she should have separated Resident #70's labia area and completely cleaned the bowel movement and swept the resident's anal area several times.</p> <p>In an interview on 02/20/2025 at 4:00 p.m. the DON stated CNA-D should have separated Resident #70's labia area to clean the base of labia and completely cleaned the bowel movement and swept the resident's anal area several times to prevent possible urinary tract infection.</p> <p>Record review of the facility policy, titled Routine procedures - Perineal Care, revised 07/2013, revealed It is the policy of this facility to prevent irritation of infection. Female-without catheter 4. Wash pubic area, including upper, inner aspect of both thighs and frontal portion of perineum - A. Use long strokes from the most anterior down to the base of labia (wash from the cleanest area to the dirtiest area) . 9. Wash perineal area thoroughly, with each stroke beginning at the base of the labia and extending up over the buttocks. - Washing should alternate side to side, ending with the center anal area.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice for 2 of 4 (Resident #70 and #52) reviewed for respiratory care.</p> <ol style="list-style-type: none"> <li>1. Resident #70's physician order indicated Changing oxygen tubing and humidifier bottle every night shift every Wednesday, but the resident's oxygen tubing labeled 02/03/2025 was not changed every week per the physician's order.</li> <li>2. Resident #52's oxygen nasal cannular and mask for Bi-pap were not covered in a plastic bag when they were not used.</li> </ol> <p>This failure could affect residents with oxygen therapy and could lead them to lack of care including possible infection by not following the physician orders.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #70's face sheet, dated 02/18/2025, revealed a [AGE] year-old female and admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease of coronary artery without angina pectoris (involves plaque buildup in artery walls), transient ischemic attack (short period of symptoms similar to those of a stroke), hypertension (high blood pressure), pulmonary fibrosis (a disease where there is scarring of the lung which makes it difficult to breathe), and gastro esophageal reflux disease (stomach acid or bile irritates the food pipe lining).</li> </ol> <p>Record review of Resident #70's quarterly MDS, dated [DATE], revealed the resident's BIMS was 13 out of 15 which indicated the resident's cognition was intact, and the resident received oxygen therapy.</p> <p>Record review of Resident #70's comprehensive care plan, dated 08/27/2024, revealed the resident had oxygen therapy related to pulmonary fibrosis and for intervention - change oxygen tubing and humidifier bottle every night shift every Wednesday.</p> <p>Record review of Resident #70's physician's order, dated 01/21/2025, revealed the resident had the order of change oxygen tubing and humidifier bottle every night shift every Wednesday.</p> <p>Observation on 02/18/2025 at 1:30 p.m. revealed Resident #70 was receiving oxygen 2 liters per minutes with a nasal cannula in her room, she said she was using oxygen continually, and the tubing between a humidifier bottle and an oxygen concentrator was labeled on 02/03/2025.</p> <p>Interview on 02/18/2025 at 11:21 a.m. LVN-C stated Resident #70 was receiving oxygen therapy, and the tubing between a humidifier bottle and an oxygen concentrator was labeled on 02/03/2025. Further interview, LVN-C said nurses should have changed all oxygen tubing and the humidifier bottle once a week every Wednesday per the physician's order and did not know what reason nurses did not follow the order.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/20/2025 at 4:00 p.m. the DON stated facility nurses should have changed Resident #70's oxygen tubing and humidifier bottle once a week every Wednesday as the physician's order to prevent possible respiratory infection.</p> <p>2. Record review of Resident #52's face sheet, dated 02/21/2025, revealed the resident was an [AGE] year old female and admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of paraplegia (inability to voluntarily move the lower parts of the body), asthma (airways become inflamed, narrow, and swell which makes it difficult to breathe), chronic respiratory failure (shortness of breath of feeling like you cannot get enough air), muscle wasting and atrophy (loss of muscle tissue and strength), and sleep apnea (breathing stops and restarts many times while sleeping).</p> <p>Record review of Resident #52's quarterly MDS assessment, dated 02/02/2025, revealed the resident's BIMS was 15 out of 15 indicated her cognition was intact, the resident was receiving oxygen therapy and non-invasive mechanical ventilator (Bi-pap).</p> <p>Record review of Resident #52's comprehensive care plan, dated 07/01/2024, revealed the resident had Oxygen therapy related to chronic respiratory failure. For intervention - oxygen 3 liter per minutes as needed and use Bi-pap at night.</p> <p>Observation on 02/18/2025 at 10:42 a.m. revealed Resident #52 was not in her room. Resident #52's nasal cannular was on the bed, and the mask of the resident's Bi-pap was on the nightstand without covering a plastic bag.</p> <p>Interview on 02/18/2025 at 11:18 a.m. LVN-C stated Resident #52's nasal cannular was on the bed, and the mask of the resident's Bi-pap was on the nightstand without a plastic bag. Further interview, LVN-C said the resident's nasal cannular and mask for the Bi-pap should have been covered in a plastic bag when they were not used to prevent possible infection.</p> <p>Interview on 02/20/2025 at 4:00 p.m. the DON stated Resident #52's nasal cannular and mask for Bi-pap should have been covered in a plastic bag when they were not used to prevent possible infections. Further interview, the DON said the facility did not have a policy related to specifically covering a nasal cannula and mask in a plastic bag when not used.</p> <p>Record review of the facility policy, titled Oxygen therapy, revised 05/2023, revealed It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>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) to meet the needs of each resident for 1 of 4 residents (Resident #32) reviewed for pharmacy services.</p> <p>Resident #32's insulin flex pen (Lispro) for diabetes had an open date of 01/10/2025 found inside the 300-hall nursing cart on 02/19/2025. It should have been discarded 28 days after opening.</p> <p>The failures could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects.</p> <p>The findings included:</p> <p>Record review of Resident #32's face sheet, dated 02/21/2025, revealed Resident #32 was a [AGE] year old female and admitted to the facility 04/11/2024 and readmitted to the facility 12/26/2024 with diagnoses of anemia (the blood does not have enough healthy red blood cells and hemoglobin), chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), hypertension (high blood pressure), and muscle wasting and atrophy (loss of muscle tissue and strength).</p> <p>Record review of Resident #32's Quarterly MDS assessment, dated 12/31/2024, revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognition was intact, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #32's physician's order, dated 12/27/2024, revealed the resident had the order of Humalog Kwik Pen subcutaneous Solution Pen Injector 100 unit/ml (insulin Lispro) inject as per sliding scale: if 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400= 10 units, 401-500=12 units Re-check blood sugar in 15 minutes. If blood sugar still 401 or greater call medical doctor., subcutaneously before meals and at bedtime related to diabetes.</p> <p>Record review of Resident #32's medication administration record, dated from 02/01/2025 to 02/28/2025, revealed Resident #32 was receiving Humalog Kwik Pen subcutaneous Solution Pen Injector 100 unit/ml (insulin Lispro) inject as per sliding scale.</p> <p>Observation on 02/19/2025 at 3:03 p.m. revealed Resident #32's insulin Kwik pen (Lispro) for diabetes with open date of 01/10/2025 inside the 300-hall nursing cart.</p> <p>Interview on 02/19/2025 at 03:07 a.m.ADON-F and LVN-G stated Resident #32's insulin Kwik pen (Lispro) for diabetes with open date of 01/10/2025 inside the 300-hall nursing cart. Further interview,ADON-F and LVN-G said Resident #32's insulin Kwik pen (Lispro) for diabetes should have been discarded 28 days after opening, which was 02/07/2025 because the nurses opened it on 0/10/2025. They did not know what reason the nurses did not discard the insulin pen.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/20/2025 at 4:00 p.m. the DON stated facility nurses should have written the open date on Resident #83's insulin pen when the nurses opened it to know they should discard it 28 days after it was opened; and the facility nurses should have discarded Resident #32's insulin Kwik pen (Lispro) for diabetes to 28 days after opening. The potential harm was the insulin pens might be less effective.</p> <p>The record review of the facility policy, titled Medication Access and Storage, revised 07/2024, revealed 12. Any opened vial without an open date will be discarded immediately and replaced with new vial. Any medication that cannot be verified as to the expiration date, either due to not being dated when opened or unclear shelf life, shall be discarded immediately and replaced.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 3 medication carts (400-hall medication aide cart) and 1 of 4 residents (Resident #83) reviewed for storage.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure the 400-hall medication aide cart was locked when left unattended during passing medications.</li> <li>Resident #83's insulin flex pen (NovoLog) for diabetes had no open date, found inside 200-hall nursing cart on 02/19/2025. Per facility policy the opened and undated insulin should have been discarded.</li> </ol> <p>This failure could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed medications.</p> <p>The findings were:</p> <ol style="list-style-type: none"> <li>Observation on 02/19/2025 at 12:09 p.m. revealed the 400-hall medication aide cart was found unlocked and unattended on the 400 hallway when Medication Aide-H was passing medications on the 400-hall. This state surveyor was able to open all drawers revealing multiple medication blister packs, scissors, and bottles of medications.</li> </ol> <p>Interview on 02/19/2025 at 12:09 p.m. Medication Aide-H stated the 400-hall medication aide cart was unlocked and unattended on the 400 hall. Medication Aide -H stated she did not realize she left the cart unlocked, and she said it was important the medication aide cart was locked at all times due to residents, visitors, and staff safety. Medication Aide-H stated by the cart being unlocked, anyone could get into the cart and take medications such as tablets and eye drops from the cart.</p> <p>Interview on 02/20/2025 at 4:00 p.m. the DON stated the 400-hall medication aide cart should not have been unlocked as it would not be safe for residents and visitors. The DON stated if the cart was not locked someone other than the nurse could open the medication cart and take out the medications. The 400-hall medication aide was responsible for overseeing this and monitored if the cart was locked sometimes.</p> <ol style="list-style-type: none"> <li>Record review of Resident #83's face sheet, dated 02/21/2025, revealed Resident #83 was a [AGE] year old male and admitted to the facility 03/31/2021 and readmitted to the facility 07/10/2023 with diagnoses of cerebral infarction (blood flow to the brain is blocked), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), hypertension (high blood pressure), and muscle wasting and atrophy (loss of muscle tissue and strength).</li> </ol> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #83's Quarterly MDS assessment, dated 01/25/2025, revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognition was intact, and the resident was receiving insulin injections every day as ordered.</p> <p>Record review of Resident #83's physician's order, dated 01/17/2025, revealed the resident had the order of Novolog Flex Pen Subcutaneous Solution Pen injector 100 unit/ml (insulin Aspart) inject 16 unit subcutaneously one time a day for diabetes.</p> <p>Record review of Resident #83's medication administration record, dated from 02/01/2025 to 02/28/2025, revealed the resident was receiving Novolog Flex Pen Subcutaneous Solution Pen injector 100 unit/ml (insulin Aspart) inject 16 unit subcutaneously one time a day for diabetes at 7:00 am.</p> <p>Observation on 02/19/2025 at 11:27 a.m. revealed Resident #83's insulin flex pen (NovoLog) for diabetes with no open date inside the 200-hall nursing cart.</p> <p>Interview on 02/19/2025 at 11:33 a.m. LVN-E stated Resident #83's insulin flex pen (NovoLog) for diabetes with no open date was inside the 200-hall nursing cart. Further interview, LVN-E said Resident #83's insulin flex pen (NovoLog) for diabetes should have been discarded 28 days after opening. However, LVN-E did not know if he should discard the insulin pen because the insulin pen did not have open date. The LVN-E did not know when the facility nurses opened Resident #83's insulin pen.</p> <p>Record review of the facility's policy, titled Medication Access and Storage, revised 07/2024, revealed . 2. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Resident #56) of 8 residents reviewed, in that:</p> <p>Resident #56's personal refrigerator located in her room was observed on 02/18/2025, and there was a small plastic cup inside the refrigerator, but no date and no label on the plastic cup.</p> <p>This deficient practice could place residents at risk of foodborne illness due to consuming foods which might be spoiled.</p> <p>The findings included:</p> <p>Record review of Resident #56's face sheet, dated 02/21/2025, reflected the resident was [AGE] years old female and was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: Parkinsonism (tremor, slowed movement, rigidity, and postural instability), urinary tract infection (bladder infection), hypertensive (high blood pressure), muscle wasting and atrophy (loss of muscle tissue and strength), and gastro esophageal reflux disease (stomach acid or bile irritates the food pipe lining).</p> <p>Record review of Resident #56's quarterly MDS assessment, dated 02/07/2025, reflected the resident's BIMS was 0 out of 15 which indicated the resident had severe cognitive impairment, and the resident was independent with eating and needed to have partial/moderate assistance (helper does less than half the effort) for chair-to-bed transfer.</p> <p>Record review of Resident #56's comprehensive care plan, dated 01/23/2024, revealed the resident had the potential nutritional problem related to increase need of assist with meals and for interventions - monitor and report to medical doctor as needed for any signs and symptoms of decreased appetite, nausea and vomiting, unexpected weight loss and complained stomach pain.</p> <p>Observation on 02/18/2025 at 9:44 a.m. revealed Resident #56 was not in her room. There was a personal refrigerator in the room, and inside the refrigerator there was a small plastic cup with red-colored food, but no date and no label on the cup.</p> <p>Interview on 02/18/2025 at 9:45 a.m. LVN-C stated Resident #56's refrigerator in her room had a small plastic cup with red-colored food, but was not dated and was no labeled. It was hot sauce. The facility nurses were supposed to check it every day.</p> <p>Interview on 02/20/2025 at 4:00 p.m. the DON stated facility nurses were responsible for overseeing Resident #56's personal refrigerator and also responsible for monitoring it daily. The DON stated the resident might not have any potential harm because it was not a regular food but hot sauce.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy, titled Resident Personal Food Storage, revised 12/2023, revealed Food or beverage brought in from outside sources for storage in facility pantries, refrigerator units, or personal/resident room refrigerator units will be monitored by designated facility staff for food safety. 5. Resident and individuals bringing food on form outside sources will be educated on safe food handling and storage techniques by designated facility staff as needed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27520 39049</p> <p>Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 3 residents (Residents #52, #109, and #27) of 29 residents and for 1 of 2 shower rooms (600 W hallway) reviewed for infection control practices.</p> <ol style="list-style-type: none"> <li>1. LVN-C provided colostomy (opening for the colon through the belly) care for Resident #52 and failed to change her gloves without sanitizing or washing her hands.</li> <li>2. LVN-A entered Resident #109's room, who was on EBP, on 02/19/2025 at 4:40 p.m. and failed to put on a gown when the LVN-A was administering medications to the resident via gastrostomy tube.</li> <li>3. Medication Aide-I administered medications for high blood pressure to Resident #27, the Medication Aide-I used a blood pressure cuff of the monitor machine to take Resident #27's blood pressure without cleaning the cuff.</li> <li>4. Nursing staff failed to remove a washcloth full of feces and sanitize the shower stall after showering residents.</li> </ol> <p>These deficient practices affect residents who require assistance treatments and could place residents at risk for cross contamination and infections.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #52's face sheet, dated 02/21/2025, revealed the resident was an [AGE] year old female and admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of paraplegia (inability to voluntarily move the lower parts of the body), asthma (airways become inflamed, narrow, and swell which makes it difficult to breathe), chronic respiratory failure (shortness of breath of feeling like you cannot get enough air), muscle wasting and atrophy (loss of muscle tissue and strength), and sleep apnea (breathing stops and restarts many times while sleeping).</li> </ol> <p>Record review of Resident #52's quarterly MDS assessment, dated 02/02/2025, revealed the resident's BIMS was 15 out of 15 indicated her cognition was intact, the resident had colostomy.</p> <p>Record review of Resident #52's comprehensive care plan, dated 07/01/2024, revealed the resident had Had an alteration in gastrointestinal status related to colostomy. For intervention - Change colostomy flange every 3 to 5 days and as needed and empty colostomy bag every shift and when half full and as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Kirkwood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2590 Loop 337 N New Braunfels, TX 78130	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 02/20/2025 at 2:00 p.m. revealed LVN-C was providing colostomy care to Resident #52. After LVN-C removed the old colostomy bag, LVN-C changed her gloves without sanitizing or washing her hands. LVN-C started cleaning the stoma (small opening in the abdomen that is used to remove body waste), patted dry, and applied skin prep around the stoma. Then, LVN-C changed her gloves again without sanitizing or washing her hands and put the new colostomy bag on Resident #52.</p> <p>Interview on 02/20/2025 at 2:19 p.m. LVN-C stated she removed the old colostomy bag and changed her gloves without sanitizing or washing her hands, then started cleaning the stoma, patted dry, and applied skin prep around stoma. LVN-C the nurse changed her gloves again without sanitizing or washing her hands and put the new colostomy bag to Resident #52. Further interview, LVN-C stated she should have sanitized or washed her hands when she changed gloves to prevent possible infection.</p> <p>Interview on 02/20/2025 at 4:00 p.m. the DON stated LVN-C should have sanitized or washed her hands when each time she changed her gloves to prevent possible infection.</p> <p>2. Record review of Resident #109's face sheet, dated 02/21/2025, revealed the resident was a [AGE] year old male, admitted to the facility on [DATE], and readmitted to the facility on [DATE] with the diagnoses of cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), gastro esophageal reflux disease (stomach acid or bile irritates the food pipe lining), muscle wasting and atrophy (loss of muscle tissue and strength), dysphagia (difficulty of swallowing), and gastrostomy (creation of an artificial external opening into stomach).</p> <p>Record review of Resident #109's quarterly MDS assessment, dated 01/22/2025, revealed the resident's BIMS was 0 out of 15 which indicated the resident had severe cognitive impairment, and the resident had a feeding tube.</p> <p>Record review of Resident #109's comprehensive care plan, dated 02/05/2025, revealed the resident Had potential nutritional problem requires tube feeding related to dysphagia and For intervention - Use Enhanced Barrier Precautions.</p> <p>Observation on 02/19/2025 at 4:40 p.m. revealed there was the sign of Enhanced Barrier Precaution over the head of Resident #109's bed and indicated to put on gloves and gown when providing high-contact resident care activities such as feeding tube. When LVN-A administered medications to the resident via gastrostomy tube, the LVN-A did not wear a gown.</p> <p>Interview on 02/19/2025 at 4:57 p.m. LVN-A stated when she administered medications to Resident #109 via gastrostomy tube, she did not wear a gown because she forgot to. Further interview, LVN-A said she should have put on a gown because the resident had enhanced barrier precautions which indicated putting on gloves and gown when providing high-contact resident care activities such as a feeding tube to prevent possible infections.</p> <p>Interview on 02/20/2025 at 4:00 p.m. the DON stated LVN-A should have put on a gown because Resident #109 had enhanced barrier precautions which indicated putting on gloves and gown when providing high-contact resident care activities such as a feeding tube to prevent possible infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #27's face sheet, dated 02/21/2025, revealed the resident a [AGE] year old male, admitted to the facility on [DATE], and readmitted to the facility on [DATE] with the diagnoses of schizophrenia (disorder that affects a person's ability to think), dysphagia (difficulty of swallowing), muscle wasting and atrophy (loss of muscle tissue and strength), and atrial fibrillation (irregular and often very rapid heart rhythm).</p> <p>Record review of Resident #27's quarterly MDS assessment, dated 01/03/2025, revealed the resident's BIMS was 15 out of 15 which indicated the resident's cognition was intact, and the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for most activities such as sit to stand and chair-to-bed transfer.</p> <p>Record review of Resident #27's care plan, dated 12/15/2023, revealed the resident had a pacemaker related to atrial fibrillation and for intervention - monitor/document/report to medical doctor any sign and symptom of altered cardiac output or pacemaker malfunction, and lower than baselined blood pressure.</p> <p>Observation on 02/20/2025 at 8:42 a.m. revealed Medication Aide-I took a resident's blood pressure and then moved to Resident #27's room. Further observation on 02/20/2025 at 09:16 a.m. revealed Medication Aide-I entered Resident #27's room and measured the resident's blood pressure without cleaning the blood pressure cuff of the monitor machine that the medication aide used before going to Resident #27's room. The Medication Aide then gave a medication to Resident #27 for atrial fibrillation.</p> <p>Interview on 02/20/2025 at 9:26 a.m. Medication Aide-I stated she used the same blood pressure cuff of the monitor machine without cleaning it when she measured Resident #27's blood pressure. Further interview, the Medication Aide said she forgot it and she should have cleaned the blood pressure cuff of the machine before using it to Resident #27 to prevent possible infection.</p> <p>Interview on 02/20/2025 at 4:00 p.m. the DON stated Medication Aide-I should have cleaned the blood pressure cuff of the machine before using it to Resident #27 to prevent possible infection.</p> <p>4. Observation and interview on 02/18/25 at 03:20 PM of the W 600 hall shower room revealed a wet washcloth with a brown substance on it. Interview with ADON L revealed the substance on the washcloth was feces. She stated a CNA probably left the washcloth after showering a resident. She applied a plastic glove, took the washcloth, turned it over and there was a clump of feces on it. ADON L stated the CNA should have rinsed the washcloth, put it in a plastic bag and put it in the soiled linen barrel. ADON L stated the CNA should have sanitized the shower stall including the floor to avoid infection transmission.</p> <p>Telephone interview on 02/21/25 at 12:20 PM with the DON revealed aides should remove a washcloth with feces or a used towel in general from the shower room and placed it in the soiled linen barrel. He stated the aide should sanitize the floor and stall after showering residents to prevent the transmission of infections. He stated nursing staff should round and address any concerns with the aides. He stated the ADONs and other administrative staff would also make rounds making spot checks and should address any concerns with the charge nurses.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy, titled Infection Control, revised on 10/2022, revealed Patient-care equipment (e.g., blood pressure cuffs). It is preferred dedicated or disposable patient-care equipment be used. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient, Enhanced Barrier Protection (EBP): expand the use of personal protective equipment and refer to the use of gown and gloves during high-contact resident care activities, such as tube feeding, and Hand Hygiene - Use an alcohol-based hand rub for the following situations: . Before performing any non-surgical invasive procedures and after removing gloves.</p> <p>Review of facility policy, Infection Prevention and Control Program, Infection Prevention and Control Program - Linens, revised 9/2022, read in relevant part</p> <p>I. Policy</p> <p>Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen.</p> <p>II. Procedure:</p> <p>1. Soiled laundry and bedding (e.g., personal clothing, uniforms, scrub suits, gowns, bedsheets, blankets, towels, etc.) contaminated with blood or other potentially infectious materials must be handled as little as possible and with a minimum of agitation.</p> <p>2. Place contaminated laundry in a bag or container at the location where it is used and do not sort or rinse at the location of use.</p> <p>3. Place and transport contaminated laundry in bags or containers.</p> <p>4. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g., gowns if soiling of clothing is likely).</p> <p>5. Environmental services staff or designee will bag contaminated laundry that is to be picked up and processed.</p> <p>6. Environmental services and nursing staff will place and transport contaminated laundry that is wet enough to potentially leak or soak through the bag or container in double bags, or leak-proof bags or containers.</p>		