STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455800	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev Attown Park	8820 Town Park Dr Houston, TX 77036

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1 of 5 residents (Resident #46) reviewed for incontinent care and indwelling catheter. 1.The facility failed to ensure CNA A cleaned Resident #46's indwelling Foley catheter properly and followed proper hand hygiene during incontinent care. These failures could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #46's face sheet revealed an [AGE] year-old who was originally admitted to the facility on [DATE]. Her medical diagnoses included diverticulitis of the intestine (inflammation of the pockets, called diverticula, located in your colon), Type 2 diabetes mellitus, cognitive communication deficit, recurrent depressive disorders (lack interest with daily activities), unspecified dementia, acute kidney failure, chronic pain syndrome, neuralgia and neuritis (pain and inflammation of the nerves), neuromuscular dysfunction of the bladder, primary hypertension(high blood pressure), and dysphagia (difficulty swallowing). Record review of Resident #46's MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status, a measure of cognitive function, with 15 being the highest cognitive function). BIMS score of 7 meaning Resident # 46 was severely impaired. Record review of Resident #46's care plan revised 10/04/2022 revealed resident was care-planned for the following: 1. Resident #46 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Activity intolerance, impaired balance -Interventions for Toilet Use: The resident is totally dependent on (x 1) staff for toilet use 2. Resident #46 has bowel incontinence r/t immobility, poor gait & balance (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Check resident frequently and assist with toileting as needed, Provide peri care after each incontinent episode Record review of Resident #46's MAR (Medication Administration Record) for December 2023 to January 2024 revealed resident was given Doxycycline Hyclate Oral Tablet 100 MG, 1 tablet via G-tube every 12 hours for infection for 7 Days until finished. The medication was administered from 12/28/2023 to 1/4/2024. Record review of Resident #46's hospital records dated 02/29/2024 revealed they were hospitalized from 02/21/2024 to 02/29/2024 due to UTI. At the hospital, she completed intra venous (IV)meropenem + Sodium Chloride 0.9% IV 100 mL 500 mg IVPB ABXQ8H. 33.33 ml/hr from 02/22/2024 to 02/29/2024. Observation of Resident # 46's Foley catheter care on 05/07/24 at 10:59 AM with CNA A and CNA D assisting, revealed CNA A washed hands and donned(put on) clean gloves and she did not open the labia to clean. Using the wet wipes, CNA A cleaned the Foley catheter tubing not in a circular motion, C.NA A used the wet wipes, cleaned catheter tubing straight and she changed gloves x 4 times and did not wash her hands or used hand sanitizer. Interview with CNA A (Lead C.NA) on 05/07/24 at 12:20 PM regarding her technique of cleaning the indwelling catheter, she said she did a good job. C.NA A said she forget to open and clean Resident #46's labia and forgot to clean the indwelling catheter from the insertion site in a circular motion. C.NA A said not opening the labia to clean and not cleaning the Foley catheter could result in infection. C.NA A said she had training for incontinent care and hand washing monthly and she monitors other C.NA for incontinent care. C. NA A said she forget to wash her hands or use hand sanitizer, she knew not washing hands or using hand sanitizer after gloving dirty could result to reinfecting resident, C.NA A said she was sorry. During an interview with the DON on 05/07/2024 at 2:25 PM., the DON stated that during the incontinent care of a female resident, Staff should wipe the peri area, then open the labia and clean downward and clean the indwelling catheter in a circular motion. The DON said she was going to start incontinence care skills checks . DON said the ADON and the lead C.NA A does incontinent monitoring. The DON stated that if staff performed peri care deviating from policy, residents risked possible urinary infections. The DON did not have policy for incontinent and Foley catheter care. In an interview on 05/08/2024 at 2:35 PM, the Administrator stated her expectation was that incontinent care and hand washing were always done to prevent infection.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review, the facility failed to ensure that a who needs respiratory care, including tracheotomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of two residents reviewed for tracheotomy care (Resident #16) A) The facility failed to ensure LVN A used sterile technique during tracheotomy suctioning for Resident #16. B) The facility failed to ensure Resident #16's oxygen was set per physician orders. These failures placed residents with tracheostomies requiring suctioning at risk for respiratory infections, hospitalization s, and a decline in their quality of life. Findings included. Record review of Resident #16's face sheet revealed he was a [AGE] year-old male who was originally admitted on [DATE]. His medical diagnoses included cerebral palsy,(a problem that affects muscle tone, movement, and coordination) tracheostomy status,(a procedure to help air and oxygen reach the lungs by creating an opening into the trachea(windpipe) from outside the neck) gastrostomy status,(opening and inserting tube used to feed) neuromuscular dysfunction of bladder,(lacks bladder control due to brain, spinal cord or nerve problem),Congenital Hydrocephalus ,(a rare brain malformation that occurs when too much cerebrospinal fluid builds up in the brain at birth)recurrent depressive disorders(feeling of sadness or loss of interest), and Epilepsy(abnormal electrical brain activity also known as a seizure). Record review of Resident #16's MDS dated [DATE] revealed the BIMS assessment was not done because the resident is rarely or never understood. Further review revealed the staff assessed Resident #16 on mental status and found he has short-term, long-term and memory/recall ability problems. Further review revealed that Resident #16 is dependent on staff for care, which means the resident does none of the effort to complete the activity, Record review of Resident #16's Physician Orders reviewed 08/24/2016 revealed the following: 1. Tracheostomy Care every shift and PRN. Clean or change inner cannula when needed Shiley 4.5 2.Tracheostomy site dressing change every DAY and PRN if soiled. 3. Suction tracheostomy tube as needed to clear airway. Document results in Progress notes 4. Trach suctioning Q shift and PRN 5. Oxygen at 4-6L/min via Tracheostomy (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #16's Care plan revised 01/24/2024 revealed resident was care-planned for: 1. Resident #16 has a Tracheostomy r/t respiratory failure -Interventions: Suction as necessary, use Universal Precautions as appropriate Interview and observation of Resident #16 on 5/6/2024 at 10:00am revealed the resident was observed laying in bed with the head at a 30-degree angle. The resident said How are you doing when surveyor greeted him. He was able to answer yes or no to some questions but stopped responding afterward. Resident was seen smiling and moving his head up and down. Resident #16's oxygen concentrator read 3. 5L/min. Resident did not appear to be in distress. Observation of Resident #16 on 5/6/2024 at 2:57pm, resident was observed lying in bed with the head at a 30-degree angle. Resident #16's oxygen concentrator read 3.5L/min. The resident had foam coming out of his mouth but did not appear to be in distress. Observation on 05/08/2024 at 10:54 AM revealed Resident #16 was in bed with audible moist breath sounds. LVN A stated resident was not usually this moist and they changed the resident's inner cannula every day. LVN A set up a clean field on the bedside table, checked oxygen saturation checked and it was 96%. LVN A donned clean gloves, picked up Trach Care Kit without changing gloves. LVN A opened the sterile Trach Care Kit, using the same gloves picked up sterile 4x4 gauze, brush and sterile gloves placed on the bedside table. She changed gloves without washing hands or using hand sanitizer, grabbed the sterile suction catheter kit tray, opened it, then doff gloves without washing hands, picked up the sterile gloves, don sterile gloves then picked up normal saline at Resident #16's bed side, poured it in the tray. LVN A picked up the suction tubing from the sterile suction kit connected it to the suction machine at Resident #16's bed side. LVN A then used the sterile gloved right hand removed oxygen mask on Resident #16's trach, then inserted suction catheter into the tracheostomy tube x 2 times, then rinsed tubing with normal saline. LVN A, using the same gloves, removed tracheostomy inner canula, then picked a syringe 10 ml normal saline (NS) covered with plastic wrap, LVN A unwrapped NS the rinsed tracheostomy inner cannula x 2 times, then re-inserted it to trach site. In an interview on 05/08/2024 at 11:30 AM, LVN A stated she did not wash her hands during trach care or do suctioning right. She stated she should have used sterile technique throughout, and she had last in-service on tracheostomy care in September 2023 and not suctioning tracheostomy with cleaned technique could result infection or cardiac arrest. She stated she works with Resident #16 most of the time. In an interview on 05/08/2024 at 12:45 PM, when Surveyor described the observed trach care, suctioning for Resident #16, the DON stated she brought in an RT that had not been in the facility for a while, because the facility changed company and she would be looking for another company to perform in-services on tracheostomy. The DON said the last in-services on tracheostomy was September 2023. The DON said LVN A always worked with Resident #16. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the website www.tracheostomyeducation.com dated 09/21/2022 reflected The upper airway plays an important role in immune defenses of the lung by filtering, humidifying, and warming inspired gases before they reach the trachea, preventing dehydration of airway secretions. The nose and oropharynx perform most of this conditioning. For the lower airways and alveoli to properly function, it is important that inspired gases are fully saturated with water vapor .With a cuffed tracheostomy tube, the airflow is redirected out through the tracheostomy tube and air does not flow through the nose or nasopharynx. The natural warming, humidification and filtration system are bypassed resulting in cool and dry air entering directly through the tracheostomy tube which can easily result in: damage to the ciliated tracheal mucosa, thickening and retention of airway secretions, impaired mucociliary transport, inflammatory changes and necrosis of epithelium, impaired [NAME] activity, destruction of cellular surface of airway causing inflammation, ulceration and bleeding , reduced lung function (atelectasis/pneumonia), increased risk of bacterial infiltration. 48923

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate administration of medications for 1 of 9 residents (Resident #13) reviewed for medication administration. MA C administered Minocycline (a drug works by killing bacteria or preventing their growth), along with one daily Multi-Vitamin and Iron tablet to Resident #13, which the medication label warned against it. This failure could place residents at risk of not receiving the therapeutic benefits of their medications. Findings included: Record review of Resident #13's face sheet revealed a [AGE] years-male admitted on [DATE] and readmitted on [DATE] to the facility. His diagnoses included lymphedema,(swelling due to build-up of lymph fluid in the body) not elsewhere classified, methicillin resistant staphylococcus aureus infection(germ(bacteria) that does not got better with the type of antibiotics that uaslly cure staph infections) as the cause of diseases classified elsewhere, chronic embolism and thrombosis (blood clot) of unspecified deep veins of unspecified lower extremity, epilepsy(abnormal electrical brain activity also known as a seizure), chronic venous hypertension (idiopathic) (high blood) with ulcer and inflammation of bilateral lower extremity. Record review of Resident #13's annual MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated cognition was intact; no impairment. He needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #13's Physician Order Report for 04 /22/2023 revealed an order of Minocycline 100mg 1 capsule per oral/by mouth(PO) every 12 hours for wound infection until 05/10/2024, One daily multi-vitamin with mineral 1 tablet PO daily. and Iron tablet 325 mg 1 tablet PO daily. In an observation on 5/6/24 at 9:20 AM, of medication administration, MA C, picked up Minocycline 100mg capsule blister packet (had Take with full glass water. No antacid/vits/iron/dairy within2 hours . May cause increased photosensitivity(is a condition in which skin becomes extremely sensitive to the sun causing skin to the sun causing skin to burn more easily). blister packet from the medication cart, punched 1 capsule in a medication cup with One daily multi-vitamin with mineral 1 tablet and Iron tablet 325 mg 1 tablet and other medications and to Resident #13 by mouth. Resident #13 complained of taking too many medications at the same time. MA C said that what I go through every time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with MA C on 5/7/24 at 2:30 PM, MA C said she has been working with facility for over 1 year and she knows the five right of meds administration, she had in-services with the unit manager and was monitored during med pass and was not aware of not taking antacid/vits/iron/dairy within 2 hours after taking minocycline and she did not read it the nurse surveyor showed it to her . In an interview on 5/8/24 at 12:38 PM the DON said the staff should read the MAR and blister packet before medication administration to Residents. She said she expected nursing staff to ensure the medication order and inventory matched because the correct dosage needed to be provided to the resident and not pharmacy recommendation could cause stomach cramps and could cause drug interaction. In an interview on 5/8/23 at 12:30 PM the facility's policy on Medication Administration was requested from the DON but was not received prior to exit. In an interview on 5/8/23 at 12:46 PM the Administrator said he expected nursing staff to follow the physician orders. She said charge nurses, or the nurse managers oversaw medication administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 18% based on 6 errors out of 32 opportunities, which involved 3 of 9 residents (Resident #57, Resident #55 and Resident #13) reviewed for medication errors. MA A did not administered Metoprolol (a prescription medicine used to lower blood pressure and heart rate) and Metformin (medication used to decrease the amount of glucose - a type of sugar released into the blood stream) to Resident #57 as ordered by the physician. MA B administered Levetiracetam (a drug used to treated seizures(involuntary muscle movements -caused by epilepsy (a group of brain disorders) to Resident #55 instead of Levetiracetam 5ml as ordered by the Physician. MA C administered Minocycline (a drug works by killing bacteria or preventing their growth), with one daily Multi-Vitamin and Iron tablet to Resident #13 when the label indicatted: While taking Minocycline avoid taking vitamins/mineral, iron because it bind with Minocycline, preventing your body from fully absorbing the drug. These failures could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications. Findings included: Record review of Resident #57's face sheet revealed a female admitted on [DATE] readmitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus (blood sugar too high) without complications, cerebral infarction,(a stroke, sometimes call a brain attack, happens in one of two ways. A blocked artery or a ruptured artery) unspecified, cellulitis (bacterial skin Infection)of right lower paranoid schizophrenia(Unreasonably suspicious of other) morbid (severe) obesity due to excess calories, (over weight) unspecified intellectual disabilities(when there are limits to a person's ability to learn at an expected level and function in daily life) ,chronic ischemic heart disease(deficient of blood supply to the heart), unspecified, hyperlipidemia(high fat in the blood), unspecified, type limb. Record review of Resident #57's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15 which indicated moderate cognitive impairment. She needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #57's Physician Order Report for 08/202023 revealed an order for Metformin (Glucophage) 1000 mg 1 tablet two times daily and Metoprolol tartrate 50 mg (0.5 mg) 1 tablet twice daily order was dated 10/04/23. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.In an observation and interview on 5/5/24 at 4:45 PM MA A prepared and administered Metformin (Glucophage) 1000 mg 1 tablet from the blister packet had Take with meal and Metoprolol tartrate 50 mg (0. 5 mg= 25 mg) 1 tablet blister packet had Take with or immediately following meals) along with other additional medications to Resident #57. Resident #57 was not eating meal and was not given any snacks before administering medications. In interview on 5/5/24 at 4:49 PM MA A was asked if Resident #57 has had dinner, MA A said very soon about 5:00PM,. MA A was shown the blister packets of (Metoprolol tartrate and Metformin (Glucophage) that indicated to be given with meals, MA A said I gave Resident #57 snacks. In an interview with Resident #57 on 5/5/24 at 4: 56 PM when the surveyor asked her if she had snacks earlier, Resident #57 said she had not eaten anything, dinner would be served at 5:30PM sometimes 6:00PM Record review of facility posted menu on 5/6/24 revealed dinner was served at 5:00 PM daily. 2. Record review of Resident #55's face sheet revealed a [AGE] years-male admitted on [DATE] to the facility. His diagnoses included(lack of oxygen) acute respiratory failure with hypoxia , acute upper respiratory infection, unspecified, age-related physical debility, alcohol abuse, uncomplicated, altered mental status, unspecified, anxiety disorder, unspecified, cutaneous abscess of right lower limb, encephalopathy (any disease, disorder, or damage that affects the brain's structure or function), unspecified, cutaneous abscess of right lower limb. Record review of Resident #55's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. He needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #55's Physician Order Report for 08/20/2023 revealed an order of Levetiracetam 100mg/ml /5mls three times daily. In an observation on 5/6/24 at 8:56 AM, MA B, poured Levetiracetam 100mg/ml 6.5 mls in a medication cup. MA B kept saying it was 5cc Resident #55 is supposed to take. The surveyor pointed to the calibrated line on the medication cup for 5cc;, MA then poured out excess med to another cup and wasted it. In an interview with MA B on 5/8/24 at 11:49 AM regarding pouring the medication accurately she said she did not place the medication cup on a flat surface. She did not look at the line on the cup correctly. She said she knew to verify the line on the cup to ensure accuracy. She said the order on the MAR and the pharmacy label on the bottle told her how much liquid to give. MA B said she had training on medication monthly by the ADON and she monitors her pass medication. 3. Record review of Resident #13's face sheet revealed a [AGE] years-male admitted on [DATE] and readmitted on [DATE] to the facility. His diagnoses included lymphedema, not elsewhere classified, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity, epilepsy, unspecified, not intractable, without status epilepticus, chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's annual MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicatedcognition was intact; no impairment. He needed extensive assistance of 1-2 staff for ADLs. Record review of Resident #13's Physician Order Report for 04 /22/2023 revealed an order of Minocycline 100mg 1 capsule PO every 12 hours for wound infection until 05/10/2024, One daily multi-vitamin with mineral 1 tablet per oral PO daily and Iron tablet 325 mg 1 tablet PO daily. In an observation on 5/6/24 at 9:20 AM, of medication administration, MA C, picked up Minocycline 100mg capsule blister packet (had Take with full glass water. No antacid/vits/iron/dairy within2 hours. May cause increased photosensitivity.) blister packet from the medication cart, punched 1 capsule in a medication cup with One daily multi-vitamin with mineral 1 tablet and Iron tablet 325 mg 1 tablet and other medications and to Resident #13 by mouth. Resident #13 complained of taking too many medications at the same time. MA C said, that what I go through every time. In an interview with MA C on 5/7/24 at 2:30 PM, MA C said she has been working with facility for over 1 year and she knows the five right of meds administration, she had in-services with the unit manager and was monitored during med pass and was not aware of not taking antacid/vits/iron/dairy within 2 hours after taking minocycline and she did not read it the nurse surveyor showed it to her . In an interview on 5/8/24 at 12:38 PM the DON said the staff should read the MAR and blister packet before medication administration to Residents. She said she expected nursing staff to ensure the medication order and inventory matched because the correct dosage needed to be provided to the resident and not pharmacy recommendation could cause stomach cramps and could cause drug interaction. In an interview on 5/8/23 at 12:30 PM the facility's policy on Medication Administration was requested from the DON but was not received prior to exit. In an interview on 5/8/23 at 12:46 PM the Administrator said he expected nursing staff to follow the physician orders. She said charge nurses, or the nurse managers oversaw medication administration

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35897 Based on observation, record review and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to maintain proper temperature for leftover food from the breakfast tray line serving cart. 2. The facility failed to ensure frozen food was safely thawed. These failures could place residents who ate food from the kitchen at risk of food borne illness and disease. Findings Included: Observation and record temperature of the facility's food saved from the breakfast tray line serving cart on 05/05/24 at 1:15 PM revealed it was below the recommended temperature. During the observation dietary cook A took food temperature. Temperature of food taken were as follow: 1. A plastic bag of Scrambled eggs stored in the refrigerator since 8:00 AM with a temperature of 72 degrees Fahrenheit. 2. A plastic bag of Hard-Boiled Eggs stored in the refrigerator since 8:00 AM with a temperature of 49.2 degrees Fahrenheit. Observation of the facility Kitchen on 05/06/24 at 8:05 AM revealed a pan of frozen Pork Chops and a pan of frozen cubed pork immersed in stagnant water in the sink. The temperature of the pork chops was 69.1- and 64.2-degrees Fahrenheit. The temperature of the pork cubes was 48 degrees Fahrenheit. The temperature of the water was 75.6 degrees Fahrenheit. Interview with the Dietary Food Service Manager on 05/06/24 at 8:25 AM she stated that she is responsible in making sure that proper food temperature is always maintained. The food temperature was in the danger zone' indicating bacteria and other foodborne pathogen can grow quickly in the temperature - The Danger Zone' was 41 to 135 degrees Fahrenheit. Proper holding temperature of food is critical for resident safety and wellness. During observation and interview with the Dietary Food Service Manager on 05/06/24 at 8:30 AM she stated that frozen food must be thawed the proper way to make sure that the proper temperature is always maintained to prevent/minimize food temperature at the danger zone. (continued on next page)

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	455800	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev Attown Park	8820 Town Park Dr Houston, TX 77036

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policies and procedures for Cooling and heating Foods dated 10/01/18 read in part 1.Cooling Foods: Rapidly cool all potentially hazardous food requiring refrigeration after preparation to an internal temperature of 41 degrees Fahrenheit or below with in six hours or less. All foods are stored, prepared, and served at temperatures that prevent bacterial growth. Hot foods are maintained at 140 degrees Fahrenheit or higher and cold foods are maintained at 40 degrees Fahrenheit or below. At point of service. Record review of the facility's policies and procedures for Food Preparation & Handling dated 05/10/18 read in part .Foods may also be thawed using the following procedures: 1. Completely submerged under cold potable running water (less than 70 degrees Fahrenheit) with sufficient water velocity to agitate and float off loosened food particles into overflow. b. For a period that does not allow thawed portions of a raw animal food requiring cooking to be above 41 degrees Fahrenheit for more than 4 hours including the time the food is exposed to the running water and the time needed for preparation for cooking.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 2 of 2 Residents (Residents #46, and #16) and 2 of 2 staffs (CNA A and LVN A) reviewed for infection control. 1. CNA A failed to perform hand hygiene between glove changes when providing incontinent care for Resident #46. 2. LVN A failed to maintain a sterile technique while providing tracheostomy care to Resident #16. These failures could place residents at risk for spread of infection and cross contamination. Findings included: Resident #46 was an [AGE] year-old who was originally admitted to the facility on [DATE]. Her medical diagnoses included diverticulitis of the intestine (inflammation of the pockets, called diverticula, located in your colon), Type 2 diabetes mellitus, cognitive communication deficit, recurrent depressive disorders, unspecified dementia, acute kidney failure, chronic pain syndrome, neuralgia and neuritis (pain and inflammation of the nerves), neuromuscular dysfunction of the bladder, primary hypertension, and dysphagia(difficulty swallowing) Record review of Resident #46's MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status, a measure of cognitive function, with 15 being the highest cognitive function), Resident # 46's BIMs score of 7 means she was severely cognitive impaired. Record review of Resident #46's care plan revised 10/04/2022 revealed resident was care-planned for the following: 1. Resident #46 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Activity intolerance, impaired balance -Interventions for Toilet Use: The resident is totally dependent on (x 1) staff for toilet use 2. Resident #46 has bowel incontinence r/t immobility, poor gait & balance -Interventions: Check resident frequently and assist with toileting as needed, Provide peri care after each incontinent episode Observation of Resident # 46's Foley catheter care on 05/07/24 at 10:59 AM with CNA A and C.NA D assisting, revealed CNA A washed hands and don(put on) clean gloves during incontinent/Foley catheter care. Using the wet wipes, CNA A cleaned the Foley catheter tubing and she changed gloves x 4 times and did not wash her hands or used hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA A (Lead C.NA) on 05/07/24 at 12:20 PM regarding her technique of cleaning the indwelling catheter, she said she did a good job. C.NA A said she forget to wash hands or use hand sanitizer, she knew not washing hands or using hand sanitizer after gloving dirty could result to reinfecting resident, C.NA A said she was sorry. C.NA A said she had training for incontinent care and hand washing monthly and she monitors other C.NA for incontinent care. During an interview with the DON on 05/07/2024 at 2:25 PM., the DON stated that during the incontinent care, Staff should wash hands or use hand sanitizer with each gloves change. The DON said the facility staffs had monthly in-services with skilled check. The DON said she was going to start incontinence care and hand washing skill checks. Record review of Resident #16's face sheet revealed he was a [AGE] year-old male who was originally admitted on [DATE]. His medical diagnoses His medical diagnoses included cerebral palsy,(a problem that affects muscle tone, movement, and coordination) tracheostomy status,(a procedure to help air and oxygen reach the lungs by creating an opening into the trachea(windpipe) from outside the neck) gastrostomy status, (opening and inserting tube used to feed) neuromuscular dysfunction of bladder,(lacks bladder control due to brain, spinal cord or nerve problem),Congenital Hydrocephalus ,(a rare brain malformation that occurs when too much cerebrospinal fluid builds up in the brain at birth)recurrent depressive disorders(feeling of sadness or loss of interest), and Epilepsy(abnormal electrical brain activity also known as a seizure). Record review of Resident #16's MDS dated [DATE] revealed the BIMS assessment was not done because the resident is rarely or never understood. Further review revealed the staff assessed Resident #16 on mental status and found he has short-term, long-term and memory/recall ability problems. Further review revealed that Resident #16 is dependent on staff for care, which means the resident does none of the effort to complete the activity., Record review of Resident #16's Physician Orders reviewed 5/7/2024 revealed the following: 1. Tracheostomy Care every shift and PRN. Clean or change inner cannula when needed Shiley 4.5 2.Tracheostomy site dressing change every DAY and PRN if soiled. 3. Suction tracheostomy tube as needed to clear airway. Document results in Progress notes 4. Trach suctioning every (Q) shift and PRN 5. Oxygen at 4-6L/min via Tracheostomy Record review of Resident #16's Care plan revised 01/24/2024 revealed resident was care-planned for: 1. Resident #16 has a Tracheostomy r/t respiratory failure -Interventions: Suction as necessary, use Universal Precautions as appropriate (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation of Resident #16 on 5/6/2024 at 10:00am revealed the resident was observed laying in bed with the head at a 30-degree angle. The resident said How are you doing when surveyor greeted him. He was able to answer yes or no to some questions but stopped responding afterward. Resident was seen smiling and moving his head up and down. Resident #16's oxygen concentrator read 3. 5L/min. Resident did not appear to be in distress. Observation of Resident #16 on 5/6/2024 at 2:57pm, resident was observed lying in bed with the head at a 30-degree angle. Resident #16's oxygen concentrator read 3.5L/min. The resident had foam coming out of his mouth but did not appear to be in distress. Observation on 05/08/2024 at 10:54 AM revealed Resident #16 was in bed with audible moist breath sounds. LVN A stated resident was not usually this moist and they changed the resident's inner cannula every day. LVN A set up a clean field on the bedside table, checked oxygen saturation checked and it was 96%. LVN A donned a clean gloves, picked up Trach Care Kit without changing gloves. LVN A opened the sterile Trach Care Kit, using the same gloves picked up sterile 4x4 gauze, brush and sterile gloves placed on the bedside table. She changed gloves without washing hands or using hand sanitizer, grabbed the sterile suction catheter kit tray, opened it, then doffed (take off)gloves without washing hands, picked up the sterile gloves, don sterile gloves then picked up normal saline at Resident #16's bed side, poured it in the tray. LVN A picked up the suction tubing from the sterile suction kit connected it to the suction machine at Resident #16's bed side. LVN A then used the sterile gloved right hand removed oxygen mask on Resident #16's trach, then inserted suction catheter into the tracheostomy tube x 2 times, then rinsed tubing with normal saline. LVN A, using the same gloves, removed tracheostomy inner canula, then picked a syringe 10 ml normal saline (NS) covered with plastic wrap, LVN A unwrapped NS the rinsed tracheostomy inner cannula x 2 times, then re-inserted it to trach site. In an interview on 05/08/2024 at 11:30 AM, LVN A stated she did not wash her hands during trach care or do suctioning right. She stated she should have used sterile technique throughout, and she had last in-service on tracheostomy care in September 2023 and not suctioning tracheostomy with cleaned technique could result infection or cardiac arrest. She stated she works with Resident #16 most of the time. In an interview on 05/08/2024 at 12:45 PM, with the DON, when Surveyor described the observed during trach care, suctioning for Resident #16, the DON stated she brought in an RT that had not been in the facility for a while, because the facility changed company and she would be looking for another company to perform in-services on tracheostomy. The DON said the last in-services on tracheostomy was in September 2023 . The DON said LVN A always worked with Resident #16. 48923