STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455923	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Beeville	600 S Hillside Dr Beeville, TX 78102

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interview, and record review, the facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 of 1 resident (Resident #34) reviewed for enteral feeding. The facility failed to ensure LVN A verified placement and checked residual (something left behind) of Resident #34's G-tube (a tube into the stomach that delivers formula for nutrition and medication) by checking for tube placement and residual before enteral administration of water and medications. These failures could place residents receiving medications at increased risk of serious complications. Findings included: Review of Resident #34's face sheet dated 07/12/24, revealed the resident was a [AGE] year-old female admitted on [DATE] and initially admitted on [DATE] with diagnose that included dysphagia (difficulty or discomfort swallowing). Aphasia (a language disorder that affects how you communicate), cerebral infarction(stroke), Alzheimer's (a brain disorder that slowly destroys memory and thinking skills, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hemiplegia (one sided muscle paralysis or weakness), pain, unspecified and gastrostomy status (a tube into the stomach that delivers formula for nutrition. Record review of Resident #34's quarterly MDS assessement dated 06/28/24, revealed a BIMS score at 03 indicating severely impaired cognition. Resident #34's nutritional approach was feeding tube. Record review of Resident #34's care plan revised dated 03/19/24 revealed she had a feeding tube. Interventions included to administer fluids per G-tube as ordered. Record review of Resident #34's physician order dated 07/01/24 revealed NPO diet and order dated 10/17/22 Enteral Feed Order every shift flush tube with 30ml of water before and after medications. During an observation during medication administration on 07/11/24 at 8:45 AM of Resident #34, LVN A did not check placement or residual prior to administration of water flushes and medication through the G-tube. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455923	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation during medication administration on 07/11/24 at 08:45 AM, LVN A did not check placement of Resident #34's G-tube prior to administration of water flushes and medications through the G-tube. LVN A flushed the tube with water, he drew up the medications individually with the syringe, administered the medications using the plunger in the syringe, drew up the water between medications using the syringe, flushed the water using the plunger in the syringe, then did the final flush of the tube with water. During an interview on 07/11/24 at 08:45AM, LVN A stated he forgot to check placement and residual prior to administering water flushes and medications through the G-tube. He stated placement needs to be checked to make sure the G-tube is in the correct spot. The negative outcome was that the medication could lead to somewhere else in the body. During an interview on 7/11/24 at 3:17PM with the DON, stated that the G-tube medication administration starts by doing hand hygiene, crushing medications, getting water ready, and check residual. She stated residual needs to be checked by aspirating and make sure patent (suction and make sure it is open/unobstructed) . The DON stated the negative outcome was that the G-tube could be clogged, and resident will not get the medication. Record review of the Administering Medications through an Enteral Tube policy and procedure revised November 2018 indicated Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Steps in the Procedure: 6. Verify placement of feeding tube: a. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician.

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NAME OF PROVIDER OR SUPPLIER Birchwood of Beeville		STREET ADDRESS, CITY, STATE, ZIP CODE 600 S Hillside Dr Beeville, TX 78102	

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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** 28223 50487 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care consistent with professional standards of practice for 1 of 16 (Resident #34) residents reviewed for oxygen in that: Resident #34's oxygen tubing was not connected to the concentrator. This failure could place residents who receive oxygen at risk of developing respiratory complications and a decreased quality of care. The findings included: Record Review of Resident #34's face sheet dated 7/11/2024 indicated she was a [AGE] year old female initially admitted on [DATE] and readmitted [DATE] with the diagnoses of Chronic Obstructive Pulmonary Disease (lung disease that blocks the air flow), Cerebral Infarction (condition that occurs when blood flow is disrupted causing brain tissue to die), Severe vascular dementia (brain damage caused by multiple strokes), generalized muscle weakness. Record review of Resident #34's comprehensive care plan dated 6/21/2024 indicated Resident #34 has oxygen therapy r/t COPD, Monitor for s/sx of respiratory distress, OXYGEN SETTINGS: O2 via: NC at 2L PRN. Date Initiated: 02/22/2024 Revision on: 02/22/2024 Record Review of Resident #34's significant change Minimum Data Set assessment dated [DATE] indicated she had a BIMS score of 3 (indicting she was severely impaired). Record Review of Resident #34's significant change Minimum Data Set assessment dated [DATE] indicated she received oxygen therapy while a resident. Record review of Resident #34's July 2024 physician's orders indicated OXYGEN at 2 Liters per minute via nasal cannula as needed every shift Observation of Resident #34 on 07/11/24 at 8:10am revealed LVN A was administering Resident #34 her medications through her feeding tube. Throughout the care, LVN A did not notice Resident #34 was not receiving oxygen. Resident #34's oxygen tubing was not positioned correctly as the nasal prongs were positioned on Resident #34's left cheek rather than her nostrils . The oxygen tubing was not connected to the Oxygen concentrator however the concentrator was on and set at 2 liters per minute. LVN A checked Resident #34's oxygen saturation and received a reading of 89%. After LVN A correctly placed the oxygen tubing in Resident #34's nares and connected the tubing to the oxygen concentrator, Resident #34's oxygen saturation increased to 97% . Interview on 7/11/2024 at 8:11am with Resident #34 revealed that she was not interviewable. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN A on 7/11/24 at 8:45am revealed he was Resident #34's nurse and was not aware Resident #34 was not receiving oxygen until told by the surveyor. LVN A stated he checked Resident #34's oxygen every chance he got. LVN A stated Resident #34 was to receive continuous oxygen at 2 liters per minute. LVN A stated the negative outcome of not receiving oxygen would be oxygen saturations would drop. LVN A stated he could not recall when he was last In-serviced on respiratory care. LVN A said a reading of 89% oxygen saturation level was considered low. LVN A said a reading of 97% oxygen saturation is within normal limits. During an Interview with the DON on 07/11/24 at 3:13 PM revealed she said LVN A was in charge to check oxygen administration at least every shift and whenever the nurse was providing care. The DON stated hypoxia (low oxygen level in the blood) and respiratory distress could occur if oxygen administration was not provided as ordered. Record review of the facility's oxygen administration policy dated October 2010, reflected Oxygen therapy is administered by way of an oxygen nasal cannula, and/or nasal catheter. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head . Check the tubing connected to the oxygen cylinder to assure that is free of kinks.

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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 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48278

Based on observation, interview and record review the facility failed to ensure the medication error rate was not five percent or greater. The facility had a medication error rate of 8% based on 2 errors out of 25 opportunities, which involved 1 of 4 residents (Resident #34) reviewed for medication errors.

Resident #34's Acetaminophen-Codeine Oral Tablet was prescribed for pain and Memantine tablet was prescribed for Alzheimers were administered by Gastrostomy tube (G-Tube), and the medication cups used contained residual medication after the medications were administered.

These failures could place residents at risk of not receiving the desired therapeutic effect of their medications to manage their medical conditions and decline in health.

Findings included:

Review of Resident #34's face sheet dated 07/12/24, revealed the resident was a [AGE] year-old female admitted on [DATE] and initially admitted on [DATE] with diagnose that included dysphagia (difficulty or discomfort swallowing). Aphasia (a language disorder that affects how you communicate), cerebral infarction(stroke), Alzheimer's (a brain disorder that slowly destroys memory and thinking skills, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hemiplegia (one sided muscle paralysis or weakness), pain, unspecified and gastrostomy status (a tube into the stomach that delivers formula for nutrition and medication administration.

Record review of Resident #34's quarterly MDS assessment dated [DATE], revealed a BIMS score at 03 indicating severely impaired cognition. Resident #34's pain frequency was unable to answer due to low BIMS score.

Record review of Resident #34's care plan revised dated 03/19/24 revealed she had potential for pain. Interventions included to administer acetaminophen-codeine tablet for pain. Care plan also revealed diagnosis of Alzheimer's disease. Interventions included to administer all medication as prescribed by the physician.

Record review of Resident #34's physician order dated 06/25/24 revealed Acetaminophen-Codeine Oral Tablet 300-30 MG

(Acetaminophen w/ Codeine) Give 1 tablet via G-Tube every 6 hours as needed for pain and order dated 11/04/22 for Namenda Tablet 10 MG (Memantine HCl) Give 1 tablet via G-Tube two times a day related to Alzheimer's disease.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview during medication administration on 07/11/24 at 8:45 AM of Resident #34, LVN A poured the crushed Memantine 10mg tablet mixed with 10cc water into the syringe. He then followed that with 30cc of water. Observation of the medication cup that held the crushed Memantine, revealed a thick, residual in the bottom of the medication cup. LVN A poured the crushed Acetaminophen-Codeine 300-30mg tablet mixed with 10cc water into the syringe. He then followed with the remaining 20cc of water. Observation of the medication cup that held the crushed Acetaminophen-Codeine, revealed a thick, residual in the bottom of the medication cup due to not mixing it well. He stated that he did not notice that there was any medication residual in the medication cup. LVN A stated that giving the residents everything that is in the medication cup was important because the resident does not get their full dose. The negative outcome was that the resident might have side effects from not getting their full dose. During an interview on 7/11/24 at 3:17 PM with the DON, stated that her expectation of the nurses administering G-tube medications, was for there to not be any residual left in the medication cup. If there was medication residual, then nurse should put a little bit more water and give the amount that remained in medicine cup. DON stated the negative outcome of not doing this was the resident does not get the correct dose of medication that was ordered. Record review of the Administering Medications through an Enteral Tube policy and procedure revised November 2018 indicated Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Steps in the Procedure: 9. Dilute medication: a. Add medication and appropriate amount of water to dilute. b. Dilute crushed (powdered) medication with at least 30ml purified water (or prescribed amount).

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44748 Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 2 of 2 unit refrigerators (unit 1 and unit 2) reviewed for sanitation. The facility failed to ensure unit refrigerators were free of unlabeled and undated items. This failure could place residents at risk for foodborne illess due to cross contamination from unlabeled and undated items in the unit refrigerators. Findings included: Observation of 2 of 2 unit refrigerators (unit 1 and unit 2) on 07/11/24 at 4:10 pm revealed 1 near empty 24-ounce bottle of salad dressing, wrapped in a paper towel, was unlabeled and undated in unit 1. There were 3, 16.9-ounce bottles of water, 1 hamburger bun, 1 hamburger patty, and 1, 6.75-ounce near empty container of orange juice, all undated and unlabeled in unit 2. Interviews with LVN D and LVN E on 07/11/24 at 4:12 pm both stated the refrigerators were kept locked for patient safety because the residents were in the locked unit. They both stated only the nurse for the units held the key to the unit refrigerators. They both stated everything in the unit refrigerators was supposed to be labeled and dated. They both stated they did not know how the unlabeled and undated items got into the refrigerators or who they belonged to. They both stated it was important to have items in the unit refrigerators labeled and dated because they did not know if the items belonged to the residents or to the staff and because cross contamination could occur and make the resident's sick. They both stated the refrigerators (unit 1 and unit 2) were supposed to be only for residents, but the unlabeled and undated items did not look like resident belongings. Neither would say who or how someone else would have obtained they keys to the unit refrigerators if only the nurse had possession of the keys. An interview with the DON on 07/11/24 at 4:15 pm stated the two LVN's should know better than to allow unlabeled and undated items in the unit refrigerators because they were trained and were told by her repeatedly about labeling and dating items in the refrigerators. A facility policy regarding food storage in unit refrigerators was requested. Record review of a blue sign affixed to the front of the unit 2 refrigerator stated Personal Fridge Safety Tips and continued with, Fridge must have thermometer. Fridge must be kept at a safe temp. Fridge must be clean. All items must have a date received. Disposal of food after day seven. Keeping you safe. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy received, instead of a policy regarding food storage, titled, Foods Brought by Family/Visitors revised March 2022. Policy interpretation and implementation 5. Food brought by family/visitors that is left with the residents to consume later is labeled and stored in a manner that it is clearly distinguishable from facility prepared food. 5a. Non-perishable foods are stored in re-sealable containers with tightly fitting lids. Intact fresh fruit may be stored without a lid. 5b. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. 6. The nursing staff will discard perishable foods on or before the use by date. 7. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger. 8. Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours are discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 48278 Based observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (Resident #19 and Resident #34, and Resident #218) of five residents observed for infection control. 1. LVN A did not remove his gloves after insulin medication preparation for Resident #19 and administered insulin medication with the same pair of gloves. 2. The facility failed to ensure LVN A washed his hands or used hand sanitizer between glove changes while performing medication administration for Resident #34. 3. LVN F failed to wash her hands for 20 seconds or greater after performing wound care on Resident #218. These deficient practices have the potential to affect residents in the facility receiving care by exposing them to care that could lead to cross contamination and the spread of infection. Findings included: 1. Review of Resident #19's Face Sheet, dated 06/11/2024, reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included type 2 diabetes mellitus with hyperglycemia (high blood sugar), hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure), chronic kidney disease stage 3, and peripheral vascular disease (reduced circulation of blood to a body part, other than the brain or heart). Review of Resident #19's Quarterly MDS Assessment, dated 06/18/2024, reflected Resident #19 had a moderately cognitive impairment with a BIMS score of 12. Review of Resident #19's Comprehensive Care Plan, dated 05/06/2024, reflected Resident #19 is at risk for skin problems r/t impaired mobility, incontinence, diabetes and fragile skin from the aging process. Interventions: Notify nurse immediately of any new areas of skin breakdown. Observation and interview on 07/11/2024 at 8:45 AM revealed LVN A did not remove his gloves after insulin medication preparation for Resident #19. He walked down the hallway without removing his gloves. LVN A then proceeded to enter Resident #19's room without changing out gloves and then administered insulin. He stated he was supposed to change out gloves but forgot to change them out. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #34's face sheet dated 07/12/24, revealed the resident was [AGE] year-old female admitted on [DATE] and initially admitted on [DATE] with diagnose that including dysphagia (difficulty or discomfort swallowing). Aphasia (a language disorder that affects how you communicate), cerebral infarction (stroke), Alzheimer's (a brain disorder that slowly destroys memory and thinking skills), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hemiplegia (one sided muscle paralysis or weakness), pain, unspecified and gastrostomy status (a tube into the stomach that delivers formula for nutrition). Record review of Resident #34's quarterly MDS assessment dated [DATE], revealed a BIMS score at 03 indicating severely impaired cognition. Record review of Resident #34's care plan revised dated 03/19/24 revealed she had a feeding tube. Interventions included to clean insertion site daily as ordered, monitoring for s/s infection or breakdown such as redness, pain, drainage, swelling, and/or ulceration and report to MD if symptoms arise. Observation and interview on 07/11/2024 at 8:45 AM revealed LVN A did not wash his hands or used hand sanitizer between glove changes while performing medication administration for Resident #34. He stated he forgot to change them. LVN A stated that by not changing gloves and performing hand hygiene, it can cause contamination. He stated the negative outcome would be that it can cause contamination spread of infection to the residents. In service for infection control was done earlier this year but he is not sure of the exact month. LVN A stated infection control training was done online as well. Record review of LVN A's, Hand Washing training dated 07/10/24, revealed he performed hand washing procedure in accordance with the facility's standard of practice. 3. Record review of Resident #218's face sheet dated 7/9/24 reflected an [AGE] year-old-female with an original admitted [DATE]. Diagnoses included dementia (general decline in cognitive abilities that affects a person's ability to perform everyday tasks), Alzheimer's disease (type of brain disorder that causes problems with memory thinking and behavior), atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the atrial chambers of the heart), pain, muscle wasting and atrophy. Record review of Resident #218's physician orders dated 7/3/24 stated: -Cleanse sacrum with normal saline, pat dry with gauze and apply Triad Cream (cream that helps heal minor wounds and reduce pain) daily and as needed every day/shift. Record review of Resident 218's care plan stated: Resident #218 was at risk for skin breakdown related to abnormalities of gait & mobility. Resident #218 requires assistance with ADL's and incontinence. Interventions included: -Nystatin Powder to buttocks every shift for rash. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Keep skin clean and dry. Use lotion on dry skin. -Weekly skin assessments. Record review of Resident #218's quarterly MDS dated [DATE] reflected a BIMS score 5 (severe cognitive impairment) and at risk for developing a pressure ulcer/injury. During an observation of wound care on 07/09/24 at 03:10 PM LVN F performed wound care as ordered on Resident #218. LVN F removed her gloves and washed hands for approximately 11 seconds. In an interview on 07/09/24 03:20 PM LVN F stated handwashing should be about 20 seconds from start to finish. LVN F stated she sang the Happy Birthday song twice in her head and thought she washed her hands long enough. LVN F stated it was important to wash hands correctly to stop the spread of infections to residents, staff, and visitors. LVN stated the last in-service on handwashing was approximately 6 months ago but could not remember. In an interview on 07/09/24 at 03:35 PM the DON stated handwashing should be 20 seconds or greater and all staff are expected to wash their hands according to CDC guidelines. The DON stated while washing hands, staff should lather their hands with soap and water for at least 20 seconds. The DON stated she was going to conduct a focused in-service immediately on handwashing with LVN F and staff. The DON stated it is important to wash hands accurately to make sure to kill germs and stop the spread of infection to other staff and residents. Record review on 07/09/24 at 03:43 PM of Handwashing in-service conducted on 7/9/24. In-service stated the steps on how to wash hands according to CDC guidelines and reflected hands on training for handwashing. Record review of the facility's Handwashing/Hand Hygiene Policy and procedure dated August 2019 stated: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation 1. All personnel shall be trained and regularly in-service on the importance of hand hygiene in preventing the transmission of healthcare associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations. b. Before and after direct contact with residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Before preparing or handling medications. i. After contact with a residents intact skin. m. After removing gloves. 8. Hand Hygiene is the final step after removing and disposing of personal protective equipment. Applying and Removing Gloves 1. Perform hand hygiene before applying nonsterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Record review of Hand Washing Steps provided by the facility stated: Continue rubbing your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song twice from beginning to end.