STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675067	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on interview and record review, the facility to ensure a new resident was not admitted with a mental disorder, unless the state mental health authority determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority prior to admission, that the individual requires the level of services provided by a nursing facility and if the resident requires such level of services, whether the resident requires specialized services for one (Resident #9) of six residents reviewed for PASARR screening. The facility failed to ensure Resident #9 received a PASARR level 2 evaluation. This failure could affect residents with mental illness and place them at risk of not being assessed to receive needed services. Findings included: Record review of Resident #9's Comprehensive MDS assessment, dated 08/02/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had a BIMS score of 15 which indicated her cognition was intact. Diagnoses included schizoaffective disorder (mood disorder), bipolar disorder (mood disorder with unusual shifts in mood, activity level, and concentration), respiratory failure, and diabetes (chronic disease impacting sugar levels in the blood). Record review of Resident #9's care plan initiated on 10/06/2022 and revised 07/10/2024, reflected she received psychotropic medication for schizophrenia/schizoaffective disorder and bipolar disorder; interventions included .administer medications as ordered .monitor and document behaviors and signs of interactions and side effects. She had a diagnosis of depression and was at risk for fluctuations in mood, little interest or pleasure in doing things; interventions included .encourage resident to be an active participant in decision making .encourage to get out of bed as tolerated . provide psyche (psych) consult as ordered . Record review of Resident #9's Continuity of Care Document, undated, reflected the diagnoses of bipolar disorder, effective dated 08/30/2022 and schizoaffective disorder, effective dated of 09/29/2022. Record review of Resident #9's PASARR Level 1 Screening, Section C, dated 08/30/2022, reflected the question if there was evidence or an indicator the individual had a mental illness was marked NO. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #9's psychiatric visit summary titled, Psychiatric Periodic Evaluation, date of service 09/02/2024, reflected she was hospitalized in the past due to psychosis and had a .past psychiatric history significant for schizoaffective disorder, bipolar disorders with depression . and was seen for a follow up. In an interview on 09/11/2024 at 2:11 PM with the MDS Nurse revealed she was not familiar with PASARR and residents typically had the PASARR completed upon admission. She stated she was responsible to enter data into the system and update the MDS quarterly, annually, and upon a significant change in conjunction with the interdisciplinary team assessments. She stated she was not working at the facility when Resident #9 was admitted to the facility. The MDS Nurse reviewed Resident #9's diagnoses and stated she had schizoaffective disorder, bipolar disorder, and no dementia diagnosis. She stated that she was not sure if schizoaffective disorder or bipolar disorder qualified as a mental illness for the question in Section C of the PASARR Level 1 Screening and she would follow up with the Regional Reimbursement Specialist for clarification. She stated that the PASARR screening was to ensure a resident who qualified obtained extra help, activities, or therapy. In an interview on 09/11/2024 at 2:39 PM with the MDS Nurse, she stated she had reached out to the Regional Reimbursement Coordinator and stated Resident #9 should have had a positive PASRR screening and it should have been updated on subsequent MDS reviews. She stated that the local authority had been contacted and was going to come to reassess Resident #9 and they planned to audit all other residents with schizoaffective or bipolar disorder to ensure their PASRR screening was accurate. In an interview on 09/11/2024 at 3:06 PM with the Regional Reimbursement Coordinator revealed the MDS Nurse was responsible for the PASARR assessment, and it was completed upon admission. She stated based on Resident #9's diagnoses the resident should had been referred for a PASARR Level 2 evaluation and it should have been noticed during the quarterly MDS reviews. She stated the risk to residents by not having an accurate PASRR screening and not updated on subsequent MDS reviews was the resident might not receive services they needed. Record review of the facility's PASARR policy titled Resident Assessment - Coordination with PASARR Program, dated 2022, reflected: .1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later . 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER: Gainesville Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1900 O'Neal St Gainesville, TX 76240	

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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	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** 34918 Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one of one resident (Resident #4) reviewed for feeding tubes. 1. The facility failed to ensure LVN A flushed Resident #4's G-Tube with 30 cc of water prior to the medication administration per physician's orders. 2. The facility failed to ensure LVN A dissolved all the medications prior to administration through Resident #4's G-Tube. 3. The facility failed to ensure LVN A administered medications through Resident #4's G-Tube by gravity, and instead she pushed one of the medications with the plunger and syringe. 4. The facility failed to ensure LVN A clamped the tubing before it drained completely between each medication administration. These failures could affect residents by placing them at risk of abdominal discomfort, obstruction of the G-tube and incomplete medication administrations. Findings included: Record review of Resident #4's Significant change MDS assessment, dated 06/24/24, reflected a [AGE] year-old female with and re-admitted [DATE]. Resident #4's BIMS score was 0 which indicated she was severely cognitively impaired. She was totally depended on all ADL and always incontinent of bowel and bladder and received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Diagnoses included dehydration, dysphagia (difficulty swallowing) and cerebral palsy (a congenital disorder of movement, muscle tone or posture due to abnormal brain development). Record review of Resident #4's Care Plan, initiated on 06/20/24, reflected, .Feeding tube- Enteral nutrition for nutrition and hydration, with potential for complications, side effects .Interventions Administer tube feeding and water flushes as ordered. See MD orders for current feeding orders . Record review of Resident #4's Physicians Order Report, dated 08/11/24 through 09/11/24, reflected, .Flush G-tube with 30 cc of water prior to and after medication administration, with a start date of 09/09/24. Record review of Resident #4's medication administration record for September 2024, reflected, . Flush G-tube with 30 cc of water prior to and after medication administration, with a start date of 09/09/24. (continued on next page)

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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	An observation on 09/11/24 at 09:25 a.m. revealed LVN A at the medication cart to prepare Resident #4's G-tube medications. LVN A entered the resident's room with the rolling blood pressure cuff and took the resident's blood pressure. LVN A returned to the medication cart and began pulling the resident's medication without performing hand hygiene. LVN A opened a bottle of Acidophilous 10 mg (probiotic) and poured two capsules into the lid of the bottle and then used her bare hands to put one of the capsules back into the bottle and placed the remaining capsule into a plastic cup. LVN A then opened the capsule with her bare hands into the plastic cup and diluted it with 30 cc of water. LVN A then proceed to pull Amlodipine 10 mg (blood pressure medication) 1 tablet, Vitamin C 500 mg (supplement) 1 tablet, Aspirin 81 mg (analgesic) 1 tablet, Vitamin D3 2000 units (supplement) 5 tablets to equal 10,000 units, Fibercon 625 mg (supplement) 1 tablet, Lasix 40 mg (diuretic) 1 tablet, Multivitamin (supplement) 1 tablet, Paroxetine HCL 10 mg (antidepressant) 1 tablet, Senna 8.6 mg (laxative) 1 tablet, and Prostat liquid protein 30 ml. LVN A placed each of the medications into a separate plastic cup, crushed them and diluted them with 30 cc of water and entered the resident's room with the medications. LVN A went to the resident's bathroom and filled two plastic cups with water and a larger plastic container with water and placed them on the bedside table with the medications. LVN A then donned a gown and gloves and retrieved the 60-cc piston syringe and placed the syringe in the end of the resident's G-tube and drew back 30 cc of gastric residual. She re-instilled the residual to the resident's stomach. LVN A then placed the 60-cc syringe into the G-Tube and began pouring the cup containing the Vitamin D3 without first flushing the tube with 30 cc of water. The medication had not dissolved and had visible solid particles in the cup. LVN A poured the medication into the tube. The medication would not go down the tube by gravity. LVN A then picked up the plunger and placed it into the syringe and pushed the medication. The syringe was coated with the remaining undissolved medication. LVN A then removed the plunger and poured approximately 30 cc of water allowing the tube to completely empty, before pouring the next medication. LVN A continued with the next nine medications, allowing each time for the tube to completely empty prior to pouring the water flush and the next medication. LVN A then poured the undiluted, very thick Prostat into the tube, where it stayed. LVN A then removed the syringe with the Prostat and poured it back into a cup and diluted it with water. LVN A then re-attached the syringe and poured the diluted Prostat back into the tube. After completion of the medication administration LVN A flushed the tube with 30 ccs of water. She removed her gown and gloves and returned to the medication cart. In an interview with LVN A on 09/11/24 at 9:50 a.m., she stated she was supposed to flush with 30 cc of water before and after completion of medication administration and flush with 30cc between each medication. She stated she did not know she could not push the medication when it would not go down the tube. She stated she knew the medication was not dissolved well but stated she knew she could not mix the medications prior and stated they would have required a longer time to completely dissolve. She stated she was not aware she was not supposed to let the tube empty completely between medications. She stated Resident #4 was the only resident in the facility with a G-tube and she is not normally assigned to her. She stated the resident received bolus feedings but was also eating. She stated the Prostat liquid protein should be given orally since it was so thick. In an interview on 09/11/24 at 1:00 p.m. the DON stated the facility policy was to flush G-Tubes with 30cc of water before and after medications, and medications were to be given by gravity. She stated pushing the medications could cause displacement of the tube. She stated the nurse should have made sure all the medications were dissolved and they should maintain a continuous flow of medication followed by water without allowing air in between. She stated by not keeping a consistent flow it can allow air in the resident's stomach. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of LVN A's skills check for Medication administration Via G-tube dated 03/14/24 reflected she was competent in the procedure. Record review of the facility's policy, Administering Medications through an Enteral Tube, dated March 2015, reflected, .Dilute the crushed or split medication with 15-30 ml room temperature tap water (or prescribed amount) .Administer medication by gravity flow .Pour diluted medication into the barrel of the syringe while holding the tubing slight above the level of insertion .Open the clamp and deliver mediation slowly .Clamp tubing (or begin flush) before the tubing drains completely .If administering more than one mediation, flush with 15 ml (or prescribed amount) room temperature tap water between medications .When the last of the medications begins to drain from the tubing, flush the tubing with 15 ml of warm room temperature tap water (or prescribed amount) .

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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 34918

Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three of thirteen residents (Resident #32, Resident #7, and Resident #4) reviewed for infection control.

1. The facility failed to ensure LVN A disinfected the blood pressure cuff in between blood pressure checks for Residents #32, Resident #7, and Resident #4) on 09/11/24.

2. The facility failed to ensure LVN A performed hand hygiene during medication administration and did not cross contaminate the medication for Resident #32 and Resident #7 on 09/11/24.

3. The facility failed to ensure LVN A did not cross contaminate Resident #32's eye drops, allergy nasal spray and antifungal powder during medication pass on 09/11/24.

These failures could place residents at risk of cross contamination which could result in infections or illness.

Findings include:

Record review of Resident #32's Quarterly MDS assessment, dated 08/01/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #32 had a BIMS score of 15 which indicated she was cognitively intact. Diagnoses included heart failure and cerebral vascular accident (stroke).

Record review of Resident #7's Quarterly MDS assessment, dated 08/31/24, reflected a [AGE] year-old female who re-entered the facility on 05/24/24. Resident #7 had a BIMS score of 7 which indicated she was severely cognitively impaired. Diagnoses included pneumonia (bacterial infection of the lungs) and seizure disorder.

Record review of Resident #4's Significant change MDS assessment, dated 06/24/24, reflected a [AGE] year-old female with a re-admitted [DATE]. Resident #4's BIMS score was 0 which indicated she was severely cognitively impaired. She was totally dependent on all ADLs and always incontinent of bowel and bladder and received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Diagnoses included dehydration, dysphagia (difficulty swallowing) and cerebral palsy (a congenital disorder of movement, muscle tone or posture due to abnormal brain development).

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/11/24 at 8:25 a.m. revealed LVN A at the medication cart in front of Resident #32 and Resident #7's room preparing to pass their morning medications. LVN A stated she first needed to get the resident's blood pressure. LVN A entered the resident's room with a rolling blood pressure monitor and cuff and took Resident #32's blood pressure. LVN A then went across the room and took Resident #7's blood pressure without sanitizing the blood pressure cuff or performing hand hygiene. LVN A then returned to the cart to proceed with pulling Resident #32's morning medication. LVN failed to perform hand hygiene or sanitize the blood pressure cuff. LVN A opened the medication cart and began pulling the resident morning medication. While punching Resident #32's Lisinopril out of the blister pack the pill popped out of the plastic medication cup and fell on top of the medication cart. LVN A picked up the pill with her bare hands and placed it in the medication cup with 10 other medications. LVN A then removed a bottle of artificial tears, a bottle of Flonase allergy spray and a bottle of Nystatin powder (antifungal) from the medication cart and entered the resident's room. LVN A placed the eye drops, the Nasal allergy spray, and the Nystatin powder onto the resident's bedside table without cleaning the surface of the table. LVN A administered the oral medications to Resident #32 and then went to the bathroom to obtain a paper towel. While LVN A was in the bathroom, Resident #32 picked up the bottle of Nasal spray and self-administered her nasal spray. LVN A put on gloves without performing hand hygiene and administered the eye drops to each of the resident's eyes. LVN A removed her gloves and performed hand hygiene and put on clean gloves and applied the Nystatin powder under each of the resident's breasts. LVN A removed her gloves and then went to pick up the eye drops, Allergy spray and antifungal powder when she dropped the bottle of eye drops onto the floor. LVN A picked up the eye drops and returned to the medication cart, where she placed all three items on top of the medication cart. LVN A discarded her gloves and performed hand hygiene and then picked up the eye drops, nasal spray and anti-fungal powder and placed them back in the medication cart without sanitizing them. Continued observation of medication pass with LVN A on 09/11/24 at 9:25 a.m. revealed her outside of Resident #4's room to provide G-Tube medication administration. LVN A entered the Residents room with the rolling blood pressure cuff and monitor without sanitizing it and took the resident's blood pressure. LVN A returned to the medication cart and began pulling the resident's medication without performing hand hygiene or cleaning the blood pressure cuff. LVN A opened a bottle of Acidophilous 10 mg (probiotic) and poured two capsules into the lid of the bottle and then used her bare hands to put one of the capsules back into the bottle and placed the remaining capsule into a plastic cup. LVN A then opened the capsule with her bare hands into the plastic cup and diluted it with 30 cc of water. LVN A then proceeded to pull the remaining nine medications and entered Resident #4's room. LVN A went to the resident's bathroom and filled two plastic cups with water and a larger plastic container with water and placed them on the bedside table with the medications. LVN A then donned a gown and gloves and retrieved the 60-cc piston syringe and placed the syringe in the end of the resident's G-tube and drew back 30 cc of gastric residual. She re-instilled the residual to the resident's stomach and proceeded with the medication administration. LVN A then removed her gown and gloves and returned to the medication cart and performed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on 09/11/24 at 9:50 a.m., she stated she was supposed to clean the blood pressure cuff between each resident and stated she had not done that. She stated she just forgot. She stated she should have sanitized the eye drops and other items taken into the resident's room and should not have set them on the bedside table. She stated the resident had the Flonase in her hand before she even realized it. She stated she did not know she should not have touched the pill with her hands and stated she guessed she should have discarded the pill when she dropped it on the medication cart and was not aware she could not touch the pills with her bare hands. She stated she was supposed to perform hand hygiene before and after any contact with residents and after glove removal and guessed she had missed some steps. She stated, I just messed up. She stated all these failures could result in the spread of germs and infections. In an interview with the DON on 09/11/24 at 1:05 p.m., she stated the staff were required to clean the blood pressure equipment used after each use before using it another resident. She stated failure to do this could potentially spread germs. She stated staff were to do hand hygiene before starting their medication pass and after. She stated at no time were they to touch any medication with their bare hands, and if they dropped a pill on the cart, they should discard it. She stated they should not be placing medication bottles on the bedside table unless they have sanitized it first. She stated once she dropped it on the floor, she should have discarded the bottle of artificial tears. She stated they do frequent in-services on hand hygiene. She stated they also do annual skills checks on all the staff for hand hygiene and for the nurses they do medication administration skills checks. She stated she would be do doing re-education with LVN A. Record Review of LVN A's Medication Administration skills Validation form dated 03/14/24 reflected she was competent in medication administration which included infection control practices. Record review of the facility's policy titled Handwashing/Hand Hygiene, dated October 2023, reflected, This facility consider hand hygiene the primary means to prevent the spread of healthcare-associated infections . All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .Indications for Hand Hygiene .Immediately before touching a resident .After touching a resident .after touching the resident's environment .Immediately after glove removal Record review of the facility's policy titled, Cleaning and Disinfection of Resident-Care items Equipment, dated September,2022, reflected, . non-critical items are those that come in contact with intact skin . Non-critical resident-care items include .blood pressure cuffs .and computers .Non-critical items require cleaning followed by either low or intermediated-level disinfection .Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings