| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 675112 | A. Building<br>B. Wing | 02/19/2026 |

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| Viridian Wellness & Rehabilitation | 1112 Gibbins Rd<br>Arlington, TX 76011 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen services.The facility failed to ensure that 1 of 1 container covered with plastic wrap was dated in the walk-in refrigerator. The facility failed to ensure that 56 of 56 containers in the reach-in refrigerator were labeledThe facility failed to ensure that 3 of 3 containers of salad were labeled and dated.The facility failed to ensure that 2 of 2 dietary staff properly use hair restraints during food preparation. This failure could place all residents at the facility by placing them at risk for food exposed to adulteration or potential contaminants.Findings Included:During an observation and interview on 02/17/26 at 9:19 a.m. with the Food Service Manager in the kitchen. During the brief initial tour of the kitchen, three un-labeled and un-dated containers were revealed in the Reach-in Refrigerator. The Food Service Manager identified the three containers as salads. The Reach-in Refrigerator also revealed 56 unlabeled containers. The Walk-in Refrigerator revealed 1 container covered with plastic wrap without an expiration date. During initial observation 02/17/26 at 9:19am 9:45am and follow up observations of the kitchen dietary staff were observed without properly restraining their facial hair during food preparation. Interview with the Dietary Aid on 2/17/26 at 10:00AM revealed the importance of good hand hygiene such as not touching face, hair, and hand washing prevented cross-contamination. Interview with the Food Service Manager on 2/18/2026 at 10:10 a.m. stated it was important to properly wear hair coverings to not cause cross-contamination. The Food Service Manager stated the unlabeled and undated food items in the refrigerators could cause residents to be served food not to meet their individual dietary requirements. The Food Service Manager stated having food in the refrigerator without an expiration date could cause residents to serve food that could cause negative effects for the residents. The Food Service Manager stated staff were in-serviced on labeling and dating food. The Food Service Manager stated some items were not labeled or dated as an error in properly storing the opened food.During an interview at 9:45 a.m. on 2/19/2026, with The Food Service Area Manager stated there was a food safety concern of something possibly contaminating the food when not wearing hair and facial coverings properly. The Food Service Area Manager stated the kitchen had specific labels purchased for labeling the food as part of ensuring the food was labeled and dated. The Food Service Area Manager stated an in-service that would include use of the special labels would be conducted.Record Review of the facilities undated policy titled Labeling and Dating Inservice revealed under section Guidelines for Labeling and Dating *All foods should be dated upon receipt before being stored. Record Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.Review of the Food and Drug Administration Food Code, dated 2017, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food<br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity for one (Resident #62) of five residents reviewed for dignity. The facility failed to ensure Resident #62's intravenous medications were covered with a privacy bag when he was eating lunch in the dining room area with several other residents. This failure could place residents at risk for a lack of privacy or dignity.Findings included: Record review of Resident #62's Face Sheet, dated 02/19/26, reflected he was a [AGE] year-old male who admitted to the facility on [DATE], with diagnoses including dementia (the loss of cognitive functioning that interferes with daily life and activities) and cognitive communication deficit (a condition where a person's ability to communicate effectively is impaired due to underlying cognitive difficulties). Record review of Resident #62's MDS Assessment, dated 01/01/26, reflected a Staff Assessment for Mental Status was completed and indicated he was severely cognitively impaired. Record review of Resident #62's Care Plan, undated, reflected .[Resident #62] has impaired skin integrity r/t localized bacterial infection to the left side of his face as evidenced by facial abscess. Interventions included .Administer Vanco ABX as ordered by the physician. Record review of Resident #62's Physician's Orders, dated 02/19/26, reflected he was ordered the following medications/treatments: .Normal Saline Flush Intravenous Solution 0.9% (Sodium Chloride Flush) - Use one liter intravenously one time only for Hypernatremia (a medical condition characterized by an abnormally high concentration of sodium in the blood) until 02/18/26. [Order Date 02/16/26] .Vancomycin HCl Intravenous Solution Reconstituted 1 GM (Vancomycin HCl) - Use 100 milliliter intravenously two times a day for facial abscess for 7 Days Reconstitute with 100 ml NS. [Order Date 02/17/26] Observation of Resident #62 on 02/17/26 at 12:20 p.m. revealed he was sitting in the dining room, eating lunch. Resident #62 was observed to be connected to intravenous medications; hanging from the IV pole was a bag of Normal Saline Flush Intravenous Solution 0.9% (Sodium Chloride Flush) and vile of Vancomycin HCl Intravenous Solution Reconstituted 1 GM. There was not a privacy cover for the medications. There were several other residents in the dining room at time of the observation. An attempted interview with Resident #62 on 02/17/26 at 12:25 p.m. revealed he was cognitively impaired and unable to participate in an interview. During an interview with the Director of Nursing on 02/17/26 at 12:40 p.m., she stated the expectation was for intravenous medications to have a privacy cover on them, when the resident who was receiving the medications was outside of his/her room and in a common area. The Director of Nursing stated failing to ensure a privacy cover was in place placed residents at risk of privacy/dignity issues. Record review of the facility's Dignity policy, dated 02/2021, reflected, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. and Staff protect confidential clinical information. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, for 1 of 5 residents (Resident#63) reviewed for respiratory care. The facility failed to ensure that Resident #63's oxygen tubing's were bagged in a plastic bag and stored in a drawer which was consistent with professional standards and changed and dated per physician orders. This failure could place residents at increased risk of infections. Record review of Resident #63's MDS Assessment, dated 01/09/2026, reflected the resident was a [AGE] year-old female, admitted [DATE]. She had a BIMs score of 10 indicating moderate cognitive impairment. The resident had diagnoses which included respiratory failure (when the respiratory system cannot adequately provide oxygen to the body), heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump enough blood to meet the body's needs for oxygen) and hypertension (a chronic condition defined as consistently high blood pressure). She was coded under Respiratory treatments to be receiving oxygen therapy. Record review of Resident #63's Comprehensive Care Plan revealed a care plan Date Initiated: 1/26/2026 [Resident] has an order for continuous oxygen at 2lpm via NC. [Resident] is noncompliant with the order and drops tubing to the floor. Facility intervention includes: Monitor s/sx of respiratory distress and report to MD: PRN Respiration, pulse oximetry, increased heart rate, Restlessness, diaphoresis(excessive sweating) , lethargy, confusion, atelectasis(the partial or complete collapse of one or more lobes of the lung, occurring when the tiny air sacs (alveoli) become deflated or filled with alveolar fluid), hemoptysis (the coughing up of blood or blood-tinged mucus from the airways, ranging from streaked sputum to life-threatening bleeding), cough Pleuritic pain (a sharp, stabbing chest pain that intensifies with breathing, coughing, or sneezing. It occurs when the pleura-the thin membranes lining the lungs and chest wall), accessory muscle usage, skin color. Record review of Resident #63's active physician orders, dated 02/01/2026, reflected oxygen at 2 l/m continuous via nasal cannula to keep oxygen level above 92% every shift for SOB. Start date 09/27/2023. Record review of Resident #63's active physician orders, dated 02/01/2026, reflected to change and date oxygen/Trach[esotomy] tubing weekly on Sunday 10pm-6am shift. Every night shifts every Sunday night. Start date 01/26/2024. Record review of Resident #63's active physician orders, dated 02/01/2026, reflected check to make sure all tubing for oxygen/Trach[esotomy] humidifier have been changed and dated every shift if not, change and date according. Start date 01/26/2024. During an observation on 2/18/2026 at 1:05 PM Resident 63 revealed the oxygen tubing was not dated or labeled and the nasal cannula was on the floor next to the resident's bed. Another Oxygen tubing was observed on the floor by Resident #63's motorized wheelchair the oxygen tubing was not bagged or stored in a plastic bag. During an interview on 2/18/2026 at 2:02 PM with DON revealed her expectation was the assigned nurse should check the oxygen tubing as part of overall assessment to make sure, the tubing's are dated and stored in plastic bags. She stated that Resident #63 refuses the nurses to change her oxygen tubing's and only wanted it changed by the respiratory therapist. She stated the facility policy was to change oxygen tubing every week on night shift and PRN. She stated that the tubing should be stored in plastic bags in the drawers to prevent it from getting contaminated. She stated the risk to the resident if tubing was not stored in sanitary ways, was infection. She stated that the nurses had been in serviced on infection control and oxygen tubing care. She stated that when tubing is changed the nurse should document the treatment administration record. During an interview on 2/18/2026 at 3:34 PM with LVN C She stated that if she observed oxygen tubing on the floor or contaminated, she would replace it immediately. She stated Resident#63 could remove the nasal cannula and sometimes it could end up on the floor. She stated the oxygen tubing was supposed to be changed weekly and as needed. She stated she usually checked the oxygen tubing to make sure they were dated. She stated the<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | importance of dating oxygen tubing was to track its age so it can be replaced according to the recommended schedule. She stated that she had been in serviced on infection control and oxygen tubing care. During an interview on 2/19/2026 at 1:34 PM with LVN B revealed she was Resident #63 nurse on 2/18/2026 but not aware that Resident #63 oxygen tubing was on the floor. She stated that if she observed oxygen tubing on the floor or contaminated, she would replace it immediately. She stated the oxygen tubing was supposed to be changed weekly and as needed. She stated she usually checked the oxygen tubing to make sure they were dated. She stated the importance of dating oxygen tubing was to track its age so it can be replaced according to the recommended schedule. She stated that she was in-service on infection control and oxygen tubing care. During an interview on 2/19/2026 at 2:34 PM interview with RT revealed the nurses were responsible for changing the oxygen tubing and she was aware the resident sometimes refuses the nurse to change the tubing, but she had educated the resident and reassured Resident #63 that the nurses were skilled to replace oxygen tubing. She stated she was at the facility bi-weekly, and she does replace the tubing and check on any other respiratory issues as needed. She stated that she does the respiratory care services, and the staff had been in serviced respiratory care to include changing oxygen tubing weekly and as needed. Record review of the facility policy titled Oxygen Administration Revised 10/ 2020 reflected: Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Documentation The date and time the procedure was performed. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and securing of 1 of 1 medication on 1 of 3 medication carts, reviewed for pharmacy services. The facility failed to ensure proper storage and disposal of Resident#18's Tylenol 300/30mg (controlled medication) by taping a narcotic medication. This failure could place residents at risk of drug diversion and risk of pills contamination due to broken seal. Record review of Resident #18's Quarterly MDS Assessment, dated 12/04/25, reflected the Resident #18 was a [AGE] year-old male, admitted [DATE].He had a BIMs score of 15, indicating cognitively intact. The resident had diagnoses including seizure disorder, anxiety disorder, and muscle weakness. Record review of Resident #18's Comprehensive Care Plan, dated 06/17/2025, reflected [NAME] was at risk for alteration in comfort related to: seizures, history of falls, antidepressant use. Interventions included pain meds as ordered, report unrelieved pain to MD. Record review of Resident #18's active physician orders, dated 02/19/2026, reflected the resident had orders for Tylenol with codeine #3 tablet 300-30mg (Acetaminophen-Codeine). Give 1 tablet by mouth every 6 hours as needed for pain order date 08/31/2025. During an observation on 02/18/26 at 2:45 PM of the 300 Hall Nurses Cart station, revealed Resident #18's Tylenol with codeine #3 tablet 300-30mg (Acetaminophen-Codeine) had 2 blister seals broken and taped. The damaged blister had the pill still inside secured with tape at the time the surveyor inspected the medication cart. In an interview on 02/18/26 at 2:50 PM, LVN I stated she was unaware Resident#18's Tylenol with codeine#3 tablet 300-30mg (Acetaminophen-Codeine) blister pack seal was broken. She stated that the risk of a damaged blister would be potential for drug diversion and contamination of the medication. She stated the nurses were responsible for checking the medication blister packs for broken seals during the count of narcotics during the change of shift. She stated she did not see the broken blister during the count. She stated she had been inserviced on medication storage. Interview on 2/18/26 at 2:12 PM with MA D revealed that when a narcotic bubble seal was broken he would notify the charge nurse so that the medication could be discarded. He stated he was in serviced on medication storage. Interview on 2/18/2026 at 2:15 PM with RNA revealed that when a narcotic bubble seal is broken the medication should be discarded wasted and witnessed by two nurses. She stated she had been in serviced on medication storage. In an interview on 02/19/26 at 1:04 PM, the DON stated if the blister pack seal was broken on any controlled medications the pill should be discarded witnessed by two nurses. The DON stated it was not acceptable to keep a pill in a blister pack that was opened. She stated that if a blister pack seal was broken it should not be tapped over with tape. The DON stated the risk would be losing the medication because the seal was broken. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON audit the medication carts weekly, then the pharmacy consultant checks the medication room and the medication cart every month and the last time the audited the carts was in January 2026.She stated the nurses had been in serviced on medication storage and that narcotics were not to be taped if the blister seal was broken. Review of the facility's policy Medication Storage and Labeling in the Facility Revised February 2023 reflected the following:Medications and biologicals are stored in the packaging containers or other dispensing systems they are received in. only the issuing pharmacy is authorized to transfer medications between containersIf the facility has discontinued, outdated or deteriorated medications or biologicals the dispensing pharmacy is contacted for instructions regarding returning or destroying these itemsControlled substances (listed as Scheduled II-V of the comprehensive Drug Abuse Prevention Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed except when using single unit package drug distribution sys in which the quantity store is minimal and a missing dose cane be readily detected. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable, for two (300 hall nurses cart and 300 hall Medication Aides cart) of four medication carts reviewed for medication storage. The facility failed to ensure Resident#19's IV antibiotic was initialed and date/time of administration. The facility failed to ensure Resident#19's IV tubing was dated indicating when it was initiated or last changed. The facility failed to ensure that an unopened vial of Rectacrit was observed stored unrefrigerated in the medication cart. The facility failed to ensure Zofran 4mg was labeled with the residents name. The facility failed to ensure an opened bottle of Keppra 100 mg/ml was labeled with the residents name. These failures could place residents at risk for compromised medication efficacy, unsafe administration, and increased harm to residents. Record review of Resident #19's annual MDS assessment, dated 11/22/25, reflected she was a [AGE] year-old female re-admitted to the facility on [DATE]. Her BIMs score was 15, indicating her cognitive status was intact. Her diagnoses included wound infection, pressure ulcer of sacral region stage 4. Record review of Resident #19's active care plan, as of 02/18/25, revealed:[NAME] has chronic history of infection AEB: UTI with resistive organisms' and sacrum pressure ulcer wound Infection. Facility interventions: Dressing change to IV site per orders/Protocol. Date dressing per facility protocol. Has PICC. Record review of Resident #19's active Physician Order, dated 2/17/26, reflected: Piperaciliin-Tazobactam in dex Intravenous solution (an intravenous antibiotic mixture used to treat severe bacterial infections) 4-0.5 GM/100ML use 1 dose Intravenously start date 2/5/2026. During an observation of Resident#19 on 2/17/26 at 9:37 AM revealed she was receiving Piperaciliin-Tazobactam in dex Intravenous solution 4-0.5 GM/100ML. The IV antibiotic did not have the date/time it was initiated and initial of the nurse administering medication. Surveyor also observed the IV tubing was not dated. During an interview on 2/17/26 at 9:47 AM with theRN A revealed she was the nurse that administered IV antibiotics. She stated that she forgot to date and initial the medication and the IV tubing. She stated the risk to the resident was potential for medication error and it would not be possible to know what time the medication was started and when the IV Tubing was last changed. She sated she had been in serviced on medication storage and labeling. During an observation on 12/17/26 at 2:21 PM with LVN I on the 300 nurses' medication cart revealed Zofran 4mg had no patients label, and an unopened vial of Retacrit (medication that requires refrigeration) stored in the cart and not refrigerated. During an interview on 2/17/26 at 2:12 PM with LVN I revealed she was not aware that the Zofran 4mg had no patients label and the retacrit required refrigeration. She stated the risk to the residents was medication error and medication losing its potency due to being unrefrigerated. She stated that she had been in-serviced on medication storage and labeling. During an observation on 2/17/26 at 2:12 PM the 300-hall medication aide Cart revealed Keppra (medication used to treat seizure) with no patient label. He stated nurses and CMAs were responsible for ensuring the medication carts were clean, all medications were within date, no medications were expired and all over the counter medications were dated when they opened. He stated that he had been in-serviced on medication storage. During an interview on 2/18/26 at 2:12 PM with MA D revealed that he did not know that the Keppra bottle did not have the pharmacy label with the resident's name. MA D stated nurses and MAs were responsible for ensuring the medication carts were clean, all medications were within date, and all medication that required refrigeration was stored in the refrigerator. He stated risk to the resident was medication error and medication not being effective if it is not well stored. He stated that he had been in-serviced on medication storage. He stated he had been in-serviced on medication storage. During<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | an interview on 2/18/2026 at 2:15 PM with RN A revealed nurses and MAs were responsible for ensuring the medication carts were clean, all medications were within date, and all medication that required refrigeration was stored in the refrigerator. She stated risk to the residents was medication not being effective if it is not well stored. During an interview on 2/18/2026 at 2:15 PM with LVN C revealed nurses and MAs were responsible for ensuring the medication carts were clean, all medications were within date, and all medication that required refrigeration was stored in the refrigerator. She sated before administering IV medication after doing all medication rights the administering nurse should initial and date the time of administration. She stated that all IV tubing should be dated when changed because the tube should be changed every 24 hours. She stated risk to the resident was medication would lose its potency if not stored by the manufacturer's recommendations. During an interview on 2/18/2026 at 2:15 PM with MA F revealed nurses and MAs were responsible for ensuring the medication carts were clean, all medications were within date, and all medication that required refrigeration was stored in the refrigerator. She stated risk to the residents was medication not being effective if it is not well stored. During an interview on 2/19/2026 at 11:15 AM with LVN B revealed nurses and MAs were responsible for ensuring the medication carts were clean, all medications were within date, and all medication that required refrigeration was stored in the refrigerator. She sated before administering IV medication after doing all medication rights the administering nurse should initial and date the time of administration. She stated that all IV tubing should be dated when changed. She stated risk to the residents was medication not being effective if it is not well stored. Review of the facility's policy Medication Storage and Labeling in the Facility Revised February 2023 reflected the following:1. Medications and biologicals are stored in the packaging containers or other dispensing systems they are received in. Only the issuing pharmacy is authorized to transfer medications between containers3. If the facility has discontinued, outdated or deteriorated medications or biologicals the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.6. Medication requiring refrigeration are stored in a refrigerator located in the medication room at the nurses station or other secured location. Medications are stored separately from food and are labeled accordingly.Medication labeling1. Labeling of medication and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceuticals practices.2. The medication label includes, at a minimum:a. Medication name(generic and /or brand);b. Prescribed dose;c. Strengthd. Expiration date, when applicable;e. Residents' name;f. Route of administration; andg. Appropriate instructions and precautions.8. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure they followed professional standards of practice in accordance with physician orders and facility policy for care of PICC lines for 1 of 2 (Resident #19) residents reviewed for parenteral and intravenous care. The facility failed to ensure Resident #19's PICC line dressing was intact. This failure could place the residents at risk of contamination, infection, and complications with their PICC line needed for infusion therapy.Record review of Resident #19's annual MDS assessment, dated 11/22/25, reflected she was a [AGE] year-old female re-admitted to the facility on [DATE]. Her BIMs score was 15, indicating her cognitive status was intact. Her diagnoses included wound infection, pressure ulcer of sacral region stage 4. Record review of Resident #19's active care plan, as of 02/18/25, revealed:[NAME] has chronic history of infection AEB: UTI with resistive organisms' and sacrum pressure ulcer wound Infection. Facility interventions: Dressing change to IV site per orders/Protocol. Date dressing per facility protocol. Has PICC. Record review of Resident #19's active Physician Order, dated 2/17/26, reflected: Piperaciliin-Tazobactam in Dex Intravenous solution (an intravenous antibiotic mixture used to treat severe bacterial infections), 4-0.5 GM/100ML use 1 dose Intravenously start date 2/5/2026. Record review of Resident #19's active Physician Order, dated 2/17/26, reflected: PICC line: Change PICC line dressing Q week and PRN, one time every Tuesday start date 2/2/2026. Record review of Resident #19's active Physician Order, dated 2/17/26, reflected: PICC line: monitor PICC site for s/s of infection. During an observation on 2/17/2026 at 9:37 a.m. Resident #19 IV antibiotic was infusing the PICC dressing edges of the transparent, sticky dressing was peeling away from the skin, curling upward almost exposing the insertion site. In an interview on 02/17/26 at 9:47 AM, RN A stated that she administered Residents#19 IV antibiotic. RN A stated that she observed that the PICC dressing was coming off when she administered the IV antibiotic, but because the PICC line flushed with no problem, she thought it was okay to administer the medication then have the DON change the dressing later. LVN A stated the risk associated with PICC lines was infection and the IV getting dislodged. In an interview on 02/18/26 at 2:24 PM the DON stated she was responsible for changing the PICC line dressings. She stated RN A had notified her the dressing needed to be changed and she was going to change it, but the surveyors got to it before she had a chance to change it. The DON stated nurses were expected to check the dressing every shift and during every antibiotic administration. The DON stated the primary risk associated with PICC lines was infection. She stated that the Nurses had been in serviced on IV administration. In an interview on 02/18/26 at 3:37 PM, LVN C stated before administering IV medication nurses are supposed to assess the IV site including ensuring the PICC dressing is intact. LVN A stated the risk associated with PICC lines was infection and the IV getting dislodged. She stated she had been in serviced on IV administration and IV dressing care. Record review of the facility's Midline IV Dressing Changes policy revised 12/2012 reflected:The purpose of this procedure is to prevent catheter-related infections associated with contaminated loose or soiled catheter-site dressings. |