

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Meadowbrook Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 632 Windsor Way Van Alstyne, TX 75495	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for two (Resident #1 and Resident #7) of fifteen residents reviewed for dignity.1. The facility failed to ensure CNA F properly covered Resident #1 while repositioning the resident in the hallway on 07/02/2025.2. The facility failed to ensure CNA D did not stand in front of Resident #7 while assisting the resident to eat during lunchtime on 07/01/2025. These failures could place the residents at risk of not having their right to a dignified existence maintained. Findings included: 1. Record review of Resident #1's Face Sheet, dated 07/02/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with contracture (tightening or shortening of the muscles) and muscle weakness. Record review of Resident #1's Quarterly MDS Assessment, dated 06/20/2025, reflected the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated that the resident was dependent on staff for dressing and personal hygiene. Record review of Resident #1's Comprehensive Care Plan, dated 06/20/2025, reflected the resident had contractures and one of the approaches was to assist with repositioning. Record review of Resident #1's Comprehensive Care Plan, dated 06/20/2025, reflected the resident was experiencing weakness and one of the approaches was to assist with ADLs. Observation on 07/02/2025 at 10:29 AM revealed after Resident #1 was transferred to her wheelchair, CNA F pushed the resident's wheelchair to the hallway. In the hallway, CNA F asked CNA G for assistance in repositioning the resident. The resident was facing the hallway, did not have any cover on her lower part of the body, and half of her thighs were visible. CNA G asked CNA F if she would get a blanket to cover the resident, but CNA F said to finish repositioning the resident first. Both CNAs repositioned the resident and placed some pillows under the resident's arms. In an interview on 07/02/2025 at 10:35 AM, CNA F stated he should have covered Resident #1 or pulled her clothes while repositioning her in the hallway to provide dignity and so that her brief would not be visible to other residents, staff, or visitors. He said the resident had the right to be treated with dignity and one of his duties was to provide it. Observation and interview on 07/02/2025 at 1:38 PM revealed Resident #1 was in the lobby eating snacks. When asked if it was ok with her when the staff did not cover her up in the hallway, the resident did not reply.2. Record review of Resident #7's Face Sheet, dated 07/01/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with legal blindness (vision impairment that affects central or peripheral visions or both) and lack of coordination. Record review of Resident #7's Quarterly MDS Assessment, dated 06/20/2025, reflected the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated that the resident was dependent on staff for eating. Record review of Resident #7's Comprehensive Care Plan, dated 05/12/2025, reflected the resident required assistance with ADLs and one of the approaches was to assist with eating. Record review of Resident #7's Physician Order, dated 05/28/2019, reflected EATING with assist of 1 staff. Observation on 07/01/2025 at 11:53 AM revealed CNA D was assisting Resident #7 for lunch in the dining area. CNA D was standing in front of the resident while she was feeding the resident. In an interview on 07/01/2025 at 12:17 PM, CNAD stated she should be sitting down when assisting somebody in the dining area. She said she assisted Resident #7 during lunch until somebody relieved her. She said, when assisting somebody during mealtimes, she should sit down so she would be face to face with the resident. She said standing up in front of the resident was not a way of showing respect and dignity and as if she was implying to the resident to hurry up. She said her mind was already on the trays on the hallway that she needed to pass. She said he ADON whispered to her that she should be sitting down but somebody already came to relieve her so she could pass the trays. Observation and interview on 07/01/2025 at 2:07 PM revealed when asked if it was ok when staff were standing up when assisting her during mealtimes, Resident #7 did not reply. In an interview on 07/02/2025 at 2:28 PM, the DON stated staff should cover the residents before ushering them in the hallway to prevent improper exposure of the resident as well as a feeling of embarrassment. She said before pushing the residents out of their rooms, the residents should be well-groomed and decent. She said the staff should sit down next to the resident when assisting them during mealtimes. She said sitting beside the resident also allowed close observation of the resident's eating habits like if the residents were swallowing the food, if there was a problem in swallowing, if the resident was choking the food, if the residents were choking. She</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>(continued on next page)</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy and confidentiality of his or her personal and medical records for seven (Resident #1, #2, #16, #20, #22, #24, and #25) of seventeen residents reviewed for privacy and confidentiality.1. The facility failed to ensure a list of hospice residents (Residents #2, #22, #24) was not left on top of the CNA's cubicle unattended on 07/01/2025.2. The facility failed to ensure MA B did not leave Resident #16's blister pack (a type of packaging in which a product is sealed in plastic, often with a cardboard backing) for potassium on top of the medication cart unattended on 07/01/2025.3. The facility failed to ensure RN A did not leave Resident #25's order for wound care on top of treatment cart unattended on 07/02/2025.4. The facility failed to ensure MA C did not leave the names of the medications to be re-ordered for Resident #20 and Resident #25 on top of the medication cart unattended on 07/02/2025. 5. The facility failed to ensure CNA F and CNA G would close Resident #1's door while doing transfer via mechanical lift (a device used to lift, transfer, or position an individual with limited mobility), did not perform ADLs in the hallway, and did not reposition the resident in the hallway on 07/02/2025.These failures could place the residents at risk of not having their personal privacy maintained during transfer and ADLs and their medical information exposed to unauthorized individuals.Findings included: 1. Record review of Resident #2's Face Sheet, dated 07/01/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with multiple sclerosis (a disease that causes breakdown of the protective covering of the nerves). Record review of Resident #2's Quarterly MDS Assessment, dated 06/06/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated the resident was on hospice. Record review of Resident #2's Care Plan, dated 06/09/2025, reflected the resident required hospice due to terminal illness of multiple sclerosis and one of the approaches was to report decline in condition to hospice agency. Record review of Resident #22's Face Sheet, dated 07/01/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #22's Quarterly MDS Assessment, dated 05/14/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated the resident was on hospice. Record review of Resident #22's Care Plan, dated 05/13/2025, reflected the resident required Hospice due to terminal illness of chronic obstructive pulmonary disease and one of the approaches was to report decline in condition to hospice agency.Record review of Resident #24's Face Sheet, dated 07/01/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with coronary artery disease (heart disease caused by plaque buildup in the arteries). Record review of Resident #24's Quarterly MDS Assessment, dated 06/06/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated the resident was on hospice. Record review of Resident #24's Care Plan, dated 06/13/2025, reflected the resident required Hospice due to terminal illness of coronary artery and one of the approaches was to call hospice for any concerns.Observation on 07/01/2025 at 8:44 AM revealed a piece of paper was on top of a cubicle on the hallway. On the piece of paper were names of residents who were on hospice.Observation and interview on 07/01/2025 at 9:12 AM, RN A stated the list of residents on hospice should not be left in the hallway because those were medical information and a HIPAA (law protecting health information aimed to ensure confidentiality) violation. RN A took the paper from the cubicle and said she would place it somewhere in the nurse's station. 2. Record review of Resident #16's Face Sheet, dated 07/01/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle wasting. Record review of Resident #16's Quarterly MDS Assessment, dated 04/29/2025, reflected the resident had severe impairment (requires significant assistance and support in daily life) in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident had muscle wasting. Record review of Resident #16's Care Plan, dated 05/01/2025, reflected the resident had nine or more medications required and one of the approaches was to monitor laboratory results.Record review of Resident #16's Physician Order, dated 12/90/2020, reflected potassium chloride 20 meq 1 tablet Once A DayObservation on 07/01/2025 at 8:45 AM revealed Resident #16's blister pack was on top of the medication cart. The blister pack had the resident's name, name of medication, the prescription number, the name of the medical doctor, and the instruction on how to take the</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 8 of 15 resident rooms on the [NAME] Hall (Resident rooms #1, #2, #3, #4, #5, #6, #7, and #8) reviewed for environment. The facility failed to ensure Resident rooms #1, #2, #3, #4, #5, #6, #7, and #8 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings include: An observation on 07/01/25 at 10:13 AM of resident room [ROOM NUMBER] reflected a mini fridge with brown stains on the bottom of the inside of it. The room floor had thick dark dirt stains along the edges and corners of the floor. The bathroom floors had dark stains along the corners of the floor and behind the toilet. The bathroom sink had stains inside the bowl of the sink. The air vent had black dirt on the vents. An observation on 07/01/25 at 10:16 AM of resident room [ROOM NUMBER] reflected a mini fridge with brownish and reddish stains on the bottom of the inside of it. The room floor had thick dark dirt stains along the edges, behind the bed, and corners of the floor. The inside resident door had red stains on the bottom portion of the door. An observation on 07/01/25 at 10:19 AM of resident room [ROOM NUMBER] reflected the air conditioning unit filters had thick dust in them. The air vents had black dirt on the vents. The room floor had thick dark dirt stains along the edges and corners of the floor. The bathroom floor had dark reddish stains behind the toilet and the bathroom had a strong unpleasant odor. The bathroom wall near the door had brown stains streaking down the bathroom tile and door frame. An observation on 07/01/25 at 10:24 AM of resident room [ROOM NUMBER] reflected the room floor had thick dark dirt stains along the edges, near a resident bed, and corners of the floor. A wall near a resident's bed had large scrapings. The air vent had black dirt on the vents. An observation on 07/01/25 at 10:27 AM of resident room [ROOM NUMBER] reflected a mini fridge with brownish and reddish stains on the bottom of the inside of it and on the floor in front of the fridge. The room floor had thick dark dirt stains along the edges and corners of the floor. An observation on 07/01/25 at 10:29 AM of resident room [ROOM NUMBER] reflected the room floor had thick dark dirt stains along the edges and corners of the floor. An observation on 07/01/25 at 10:33 AM of resident room [ROOM NUMBER] reflected the room floor had thick dark dirt stains along the edges and corners of the floor. An observation on 07/01/25 at 10:35 AM of resident room [ROOM NUMBER] reflected the room floor had thick dark dirt stains along the edges and corners of the floor. In an interview on 07/03/25 at 09:16 AM, Housekeeping J stated he was responsible for cleaning the rooms on the [NAME] side of the facility. He stated he was supposed to clean the floor, air vents, bathrooms, and wipe down the walls. He stated he did not clean the resident mini fridges in the rooms unless they asked him to. He was shown pictures of the concerns observed in Resident Rooms #1, #2, #3, #4, #5, #6, #7, and #8. He stated he normally cleaned the areas observed. He did not state why the areas of concern were not cleaned. He stated not cleaning the rooms and the hallway floors could result in germs being spread. In an interview on 07/03/25 at 9:21 AM, the Maintenance/Housekeeping Director, stated he was responsible for supervising the staff on cleaning the facility. He stated staff was responsible for cleaning the floors, empty the trashcans, dust the vents, clean the bathrooms, wiping down the walls, and the hallway floors. He stated the nursing staff was responsible for checking the mini fridges in the resident rooms but they could clean them if needed. He was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, and #8. He stated he currently did not have a working buffer to thoroughly clean the floors. He stated he was responsible for repairing any damaged walls. He stated during Angels rounds, staff was responsible for checking the rooms for cleanliness and he also checked rooms for cleanliness multiple times a week. He stated if the rooms and halls were not thoroughly cleaned it could result in health issues for the residents. In an interview on 07/03/25 at 9:45 AM, the Administrator stated she had met with the Maintenance/Housekeeping Director, and he had briefed her on the concerns observed. She was shown pictures of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, and #8. She stated her staff cleaned the rooms and they typically were told by others that they had a clean facility. She stated they completed Angel rounds daily and one of the areas observed was the cleanliness of the resident rooms. She stated it was the entire staff's responsibility to clean the resident refrigerators in the resident rooms. She stated she expected the housekeeping staff to thoroughly clean the resident rooms and hall floors. She stated not cleaning the areas</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 1 of 6 residents (Resident #22) reviewed for accident prevention. The facility failed to ensure Resident #22's fall mat was placed alongside his bed for fall prevention. This failure could prevent the resident from having an environment that was free and clear of accidents and hazards. Findings include: Record review of Resident #22's Face Sheet, dated 07/01/25, reflected he was an [AGE] year-old male admitted on [DATE]. Relevant diagnoses included repeated falls, and dementia (memory loss). Record review of Resident #22's Quarterly MDS assessment, dated 05/14/25, reflected he had a BIMS score of 9 (moderate cognitive impairment). For ADL care, it reflected the resident required extensive assistance and an active diagnosis included quadriplegia (paralysis of lower extremity). Record review of Resident #22's Comprehensive Care Plan, dated 05/14/25, reflected the resident was a fall risk and two of the interventions was to be ensure a fall mat placed alongside the resident's bed. An observation on 07/02/25 at 9:45 AM of Resident #22 revealed the resident lying in bed sleeping. There was a bed side table positioned over him and the fall mat was folded and leaning against the foot of his bed. In an interview and observation on 07/02/25 at 9:48 AM, the ADON observed the resident's fall mat folded up and leaning against the foot of Resident #22's bed. She stated she had confirmed with the DON that the resident had a recent fall and required the fall mat to be placed alongside the resident's bed while he was lying in it to prevent him from injuring himself if he fell. She stated Hospice may have provided care to the resident and had forgotten to remove the bedside table and place the fall mat alongside the bed. In an interview on 07/02/25 at 11:22 AM, the DON stated she had spoken with the ADON about Resident #22 not having the fall mat placed alongside his bed after he had finished his breakfast. She stated she thought Hospice had forgotten to place the fall mat back alongside the resident's bed. She was advised that the resident was observed earlier in the morning eating his breakfast and was later observed with the bedside table still over his bed while he was lying in it and the fall mat leaning against the foot of the bed. She stated the fall mat should have been placed alongside the resident's bed to assist in preventing him from injuring himself if he fell out of the bed. She stated the resident was a fall risk. Record review of the facility's policy Fall Management (5/05/23) reflected The facility will identify each patient/resident who is at risk for falls and will plan care and implement interventions to manage falls.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #6) of eight residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #6's t-tube (used to receive medications by breathing in mist through the mouth) for breathing treatment was properly stored when not in use on 07/01/2025 and that there was a sign outside the resident's room to indicate that oxygen was in use on 07/01/2025.</p> <p>These failures could place residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings included:</p> <p>Record review of Resident #6's Face Sheet, dated 07/01/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Record review of Resident #6's Quarterly MDS Assessment, dated 05/13/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. The Quarterly MDS Assessment indicated the resident had chronic obstructive pulmonary disease and was on oxygen therapy.</p> <p>Record review of Resident #6's Comprehensive Care Plan, dated 06/30/2025, reflected the resident had chronic obstructive pulmonary disease and the approaches were to administer albuterol hfa (medication used for breathing treatment) prn and oxygen as ordered.</p> <p>Record review of Resident #6's Physician's Order, dated 06/30/2024, reflected albuterol sulfate HFA aerosol inhaler 90 mcg/actuation PRN for shortness of breath.</p> <p>Record review of Resident #6's Physician's Order, dated 05/09/2025, reflected O2 at 2 liters per minute via nasal cannula continuous every day.</p> <p>Observation and interview on 07/01/2025 at 8:32 AM revealed Resident #6 was sitting in his recliner, awake and with was on oxygen therapy. A nebulization machine was noted on top of the resident's side table with a t-tube connected to it. The t-tube was not bagged. The resident said the last time he had a breathing treatment was before he was sent out to the hospital and that was a week ago. He said he had been using oxygen even before he was admitted to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 07/01/2025 at 10:23 AM, RN A stated Resident #6's order for the breathing treatment was as needed. She said, if she was not mistaken, the last time the resident used the breathing treatment was before his last hospitalization a week ago. She said the resident used a t-tube instead of the breathing mask during the breathing treatment. She said if the resident was not using the t-tube, it should be inside a clean plastic bag to ensure cleanliness for the next use. She went inside the resident's room and saw the t-tube on the table. She disconnected the breathing mask and threw it in the trash can and said she did not notice it when she did her morning round. She said she would get another one and make sure it was inside the plastic bag to prevent any respiratory infection.</p> <p>In an interview on 07/02/2025 at 2:28 PM, the DON stated Resident #6's t-tube should be inside a plastic bag when the resident was using it to prevent cross contamination and possible infection. She said no one even knew how long it was on the side table not bagged. She said the expectation was for any breathing paraphernalia be bagged. She said she would initiate an in-service about bagging storing any breathing paraphernalia properly.</p> <p>In an interview on 07/02/2025 at 2:52 PM, the ADON stated the t-tube should be stored properly to prevent cross contamination and respiratory infections. she said whoever administered the breathing treatment was responsible in cleaning it and storing it in a plastic bag. She said the expectation was for the staff to bag the t-tube when not in use and replace it if seen not bagged. She said she would coordinate with the DON to do an in-service about the issue.</p> <p>In an interview on 07/02/2025 at 3:13 PM, The Administrator stated they were vigilant in reminding the staff to bag the respiratory paraphernalia that the residents were using to prevent respiratory infection. She said she would coordinate with the DON and the ADON on how to deal with the issue.</p> <p>Record review of the facility's policy RESPIRATORY TREATMENT, CARE AND SERVICES PROGRAM Nursing Policies and Procedures revised May 05,2023 revealed POLICY: The Facility ensures the safe, appropriate, and effective provision of respiratory treatment, care, and services in accordance with professional standards of practice . PROCEDURES . 6. Infection control practices including standard and transmission-based precautions are . B. Handling of equipment, including cleaning, storage . 8. Respiratory Care [NAME] elements . A. Oxygen Therapy . 2) safety precautions.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Meadowbrook Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 632 Windsor Way Van Alstyne, TX 75495	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for one (Resident #51) of ten residents reviewed for pharmaceutical services. 1. The facility failed to ensure MA B did not leave Resident #51's medications inside the resident's room for the resident to take unsupervised on 07/01/2025 2. The facility failed to ensure MA C did not put her personal beverage on the medication cart while passing medications on 07/02/2025. 3. The facility failed to ensure that there was no expired nasal sprays inside the medication room on 07/02/2025. These failures could place the residents at risk of not receiving medications as ordered by the physician. Findings included: 1. Record review of Resident #51's Face Sheet, dated 07/01/2021, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #51's Comprehensive MDS Assessment, dated 06/30/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident had generalized weakness. Record review of Resident #51's Comprehensive Care Plan, dated 06/20/2025, reflected the resident had a decline in her ability to ambulate and one of the approaches was to provide supplements and vitamins as ordered. Record review of Resident #51's Physician's Order, dated 06/24/2025, reflected provitalize 2 capsules Once A Day. Record review of Resident #51's Assessment Notes on 07/01/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage their own medications. Observation and interview on 07/01/2025 at 8:54 AM revealed Resident #51 was in her bed finishing her breakfast. It was observed that there was a small cup on her overbed table with two yellow capsules. The resident said it was left by her nurse for her to take and she was done with the rest of the pills. The resident said she would take the capsules after she was done with breakfast. In an interview on 07/01/2025 at 9:12 AM, RN A stated Resident #51's medication should not be left with the resident for her to take unsupervised. She said staff should have made sure the medications were swallowed and there was no issue while taking the medication. She said the resident might not take the pills or hide them or choke on them and nobody was there to initiate help. In an interview on 07/01/2025 at 10:45 AM, MA B stated she was inside Resident #51's room waiting for the resident to finish her medications. She said a CNA called her for assistance so she stepped out of the room and forgot to go back. She said she should have told the staff that she could not be distracted when she was administering medications. She said the resident might throw the medication or hide them. She said she would check if the resident already took the medications. She said the two yellow capsules were provitalize, a probiotic. 2. Observation on 07/02/2025 at 7:15 AM revealed MA C's personal tumbler was on top of the medication cart that she was using to pass medications. Observation and interview on 07/02/2025 at 12:27 PM revealed MA C's personal tumbler was still on top of the medication cart that she was using to pass medications. She said she always had her tumbler every time she passed medications and nobody told her she could not put it there. In an interview on 07/03/2025 at 9:12 AM, MA C stated the DON already explained to her why she could not have her personal tumbler on the cart when passing medications. She said it could be an infection control issue or could create clutter on the medication cart. She was told that only required supplies and medications should be on the medication cart. 3. Observation on 07/02/2025 at 8:15 AM revealed during inspection of the medication room, three bottles of nasal spray were dated 05/25. Observation and interview on 07/02/2025 at 8:16 AM, RN A stated the nasal sprays were expired and should not be inside the medication room. She said they were supposed to be disposed so they would not be used for the residents. She said the ADON was responsible in auditing the medication room but she would sometimes help in the checking the med room. She said they missed the three expired nasal sprays. She said the expired nasal sprays might be less effective or could cause adverse reactions. RN A took the three bottles of nasal spray and showed them to the DON. In an interview on 07/02/2025 at 2:28 PM, the DON stated a staff should never leave the medications at the bedside for the resident to take later unsupervised. She said the staff must ensure the resident took the medications before leaving the room. She said the resident could hoard or hide the pills to avoid taking them. She said the residents could overdose on hoarded pills. She said the staff should have told the staff that asked for assistance that she was passing meds and could not be distracted. She said there should be no expired medications inside the medication room or</p>		

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NAME OF PROVIDER OR SUPPLIER Meadowbrook Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 632 Windsor Way Van Alstyne, TX 75495	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for two (Resident #2 and Resident #25) of sixteen residents reviewed for medication storage. 1. The facility failed to ensure #Resident #2's anti-fungal powder was not left on top of the resident's side table on 07/01/2025. 2. The facility failed to ensure Resident #25 did not have a bottle of eyedrops on her overbed table on 07/01/2025. These failures could place the residents at risk of accidental overdose, misuse of medications, not receiving the medication's full therapeutic benefits, and possible side effects. Findings included: 1. Record review of Resident #2's Face Sheet, dated 07/01/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with depressive disorder (persistent feeling of sadness or loss of interest) and dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #2's Comprehensive MDS Assessment, dated 06/06/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 09 (resident may need additional support and monitoring). The Comprehensive MDS Assessment indicated the resident had depression. Record review of Resident #2's Comprehensive Care Plan, dated 06/09/2025, reflected the resident took an antidepressant and one of the approaches was to monitor the resident's mood and response to medication. Record review of Resident #2' Physician Order, dated 11/10/2022, reflected Anti-fungal powder to affected area. Record review of Resident #2's Assessment Notes on 07/01/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage their own medications. Observation and interview on 07/01/2025 at 8:50 AM revealed Resident #2 was in her bed, awake. It was observed that there was an antifungal powder on the resident's side table. When asked if she was using it, the resident just shrugged her shoulders. 2. Record review of Resident #25's Face Sheet, dated 07/02/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar that could potentially have an effect on the eye sight). Record review of Resident #25's Quarterly MDS Assessment, dated 04/01/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #25's Care Plan, dated 06/30/2025, reflected the resident had diabetes mellitus and one of the approaches was to monitor potential signs and symptoms . blurry eyes. Record review of Resident #25's Assessment Notes on 07/01/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage their own medications. Record review of Resident #25's Physician orders on 07/01/2025 reflected no order for eye drops. Record review of Resident #25's Physician Order, dated 12/23/2024, reflected RESIDENT MAY NOT SELF-ADMINISTER MEDICATIONS Observation and interview on 07/01/2025 at 10:08 AM revealed Resident #25 was in her bed, awake. It was observed that there was a container of eyedrops on the resident's overbed table. She said she was using it every morning because her eyes were dry when she woke up. She said the eyedrops had always been on top of her table. She said she did not know if the staff saw it or knew about it but it had been on her table. Observation and interview on 07/01/2025 at 10:23 AM, RN A stated the eyedrops should not be inside Resident #25's room unless she had an assessment that she could administer it herself. She said if the resident needed eyedrops, the staff should be the one administering it and it should be stored inside the cart. She went inside Resident #25's room and talked to the resident. She said she would also call the doctor to get an order for the eyedrops. RN A then went to Resident #2's room and saw the anti-fungal powder on the side table. She said she did not know who left it on the side table. She took the anti-fungal from the side table and said she would put it inside the cart because it was a medicated powder. She said she did not see the eyedrops and the anti-fungal powder when she made her morning round. In an interview on 07/02/2025 at 2:28 PM, the DON stated no medications should be stored inside the resident's room. She said if Resident #25 needed eyedrops, the staff should be the one administering it to ensure proper use of the medication and there should be an order for. She said the anti-fungal powder is a form of medication and should be in the cart. She said whoever applied it should have not left it in Resident #2's side table because the resident, other confused residents, or a visitor might accidentally ingest it and could result in allergic reactions or other adverse outcomes. She said the expectations were for the staff to always scan the residents' rooms to make</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review the facility failed to store, prepare, distributed, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. The facility failed to place a lid on top of the trashcan to avoid air borne contaminants. The facility failed to ensure prepared food in the refrigerator was labeled and dated when stored. The facility failed to ensure foods located in the freezer were sealed from air-borne contaminants. The facility failed to ensure all foods stored in the freezer and refrigerator were labeled and dated when stored. The facility failed to dispose of expired foods in the dry storage area. The facility failed to ensure kitchen equipment was cleaned. The facility failed to ensure the kitchen and dining area was cleaned and sanitized. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings include: Observations on 07/01/25 from 8:34 AM to 8:47 AM in the facility's only kitchen revealed: One large trashcan, located in the dining room, was full of trash and did not have a lid on it. A large air vent, located in the dining room, had black and reddish stains on the vents. One microwave, located in the dining room, had brownish stains all over the inside walls of it. One brown serving cart, located in the dining room, had stains, trash, and food particles all over the top of it. One zip locked bag of fruits, located in the refrigerator, was not labeled with the stored date. One gallon of Asian Sesame Dressing, located in the refrigerator, was not labeled with the stored date. One large box of French toast, located in freezer, was not sealed from air-borne contaminants. One large box of frozen waffles, located in freezer, was not sealed from air-borne contaminants. One large bag of frozen ground beef, located in the freezer, was not labeled with the date the item was stored. One ice scoop was sitting on a tray in the dining area, and not covered from air-borne contaminants. One blue ice scoop holder, located on a wall next to the ice machine, had brownish dirt particles on the inside bottom of it. Four bags of flour tortillas, located in the dry storage area, had a best by date of 6/25/25, and were not discarded. One white refrigerator, located in the dry storage area had black stains on the inside of it. One bag of frozen biscuits, located in the freezer, was dated 12/19 with a use by date of 1/13/25 was not discarded. In an interview on 7/02/25 at 12:10 PM, the Dietary manager stated the kitchen was cleaned daily and they used a cleaning schedule. He stated the microwave was scheduled to be cleaned twice a week. He stated he ensured the trashcans always had lids on them and he had forgotten to place the lid back on the trashcan. He stated he labeled and dated the food when it was stored and if food came in on the weekend, the cooks would label and date the foods. The Dietary Manager stated he was responsible for ensuring food in the freezer were sealed, foods were labeled and dated, and ensured foods were discard when it expired. He stated he had new cooks, and they were still learning so he took on these responsibilities. He stated residents could potentially get sick if these issues were not resolved. In an interview on 07/03/25 at 9:45 AM, the Administrator stated she had spoken with the Dietary Manager about the concerns observed in the kitchen area. She was also shown pictures of the concerns observed in the kitchen area. She stated her expectation was for the kitchen and kitchen equipment to be clean, expired foods to be discarded, and the foods to be properly labeled and dated. She stated not addressing the concerns observed could result in residents getting sick. Record review of the facility's policy on Food Safety in Receiving and Storage (06/20/23), revealed Foods will be received and stored by methods to minimize contamination and bacterial growth. Refrigerated, ready-to-eat Time/Temperature Control for Safety Foods are properly covered, labeled, dated with use-by-date, refrigerated immediately. Record review of the facility's policy on Sanitation & Food Safety in Food and Nutrition Services (06/20/2023), revealed The Certified Dietary Manager will assume responsibility for the food safety and sanitation of the Nutrition Culinary Department. Infection control sanitation practices are followed to minimize the risk of contamination of food and prevent foodborne illness. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and 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 two (Resident #1 and Resident #50) of fifteen residents reviewed for infection control. 1. The facility failed to ensure CNA E changed her gloves and performed hand hygiene during Resident #50's incontinent care on 07/01/2025.2. The facility failed to ensure that CNA F changed his gloves and performed hand hygiene during Resident #1's incontinent care on 07/02/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #50's Face Sheet, dated 07/02/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with urinary tract infection. Record review of Resident #50's Comprehensive MDS Assessment, dated 07/02/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident was incontinent for bladder and bowel. Record review of Resident #50's Comprehensive Care Plan, dated 04/27/2025, reflected the resident was incontinent of bowel and bladder and one of the approaches was to provide incontinence care. Observation on 07/01/2025 at 1:10 PM revealed CNA D and CNA E were about to provide incontinent care to Resident #50. Both CNAs washed their hands and put on a pair of gloves. CNA E went to right side of the resident while CNA D went to left side. Both CNAs unfastened the soiled brief and tucked it between the resident's legs. CNA D washed her hands and put on a new pair of gloves. CNA D started cleaning the resident's perineal area (area between the legs) using the front to back technique. After cleaning the perineal area, the resident was assisted to roll towards the right side and CNA D cleaned the resident's bottom. After cleaning the resident's bottom, CNA D rolled the pulled the soiled brief and threw it in the trash can. CNA E helped in rolling the soiled brief. CNA D washed her hands and put on a new pair of gloves. CNA D then took the brief and placed it under the resident. Since the resident was still in a side-lying position, CNA D told CNA E that they would switch places so CNA E could wash her hands and change her gloves. After switching places, instead of washing her hands and putting on a new pair of gloves, CNA E proceeded on fixing the new brief. CNA E still had the pair of gloves that she used to touch the soiled brief. After fixing the brief, they assisted the resident to roll back and fastened both ends of the brief. Both CNAs washed their hands. In an interview on 07/01/2025 at 1:18 PM, CNA E stated, realistically, it should not take that long to do incontinent care. She said there was a lot of things to do and sometimes there was no time to change gloves. When asked again if the gloves should be changed after touching something soiled and before touching the new brief, CNA E replied yes to prevent infection. 2. Record review of Resident #1's Face Sheet, dated 07/02/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with anoxic brain damage. Record review of Resident #1's Quarterly MDS Assessment, dated 06/20/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated that the resident was incontinent for bladder and bowel. Record review of Resident #1's Comprehensive Care Plan, dated 06/20/2025, reflected the resident was incontinent of bowel and or bladder and one of the approaches was to provide incontinence care. Observation on 07/02/2025 at 10:05 AM revealed CNA F was about to transfer Resident #1 but said he would clean her up first. He washed his hands and put on a pair of gloves. He then unfastened the resident's brief on both sides and pushed it between the resident's legs. Before starting incontinent care, he took a new brief, opened it, and placed it on the resident's side. He did not change his gloves before touching the new brief. He cleaned the resident's perineal area (area between the thighs) using the front to back technique. He did it six times. He changed his gloves but did not sanitize his hands before putting on the new pair of gloves. He then rolled the resident and started cleaning the resident's bottom. During the process, CNA F took the new brief beside the resident and placed it on the foot part of the bed. The new brief was facing down and the inner part of the brief was touching the bed. He continued to clean the resident's bottom and then pulled the new brief from the foot side of the bed and placed it under the resident. He did not change his gloves before touching the new brief. CNA F said he would clean the resident's bottom some more and placed the wipes on top of the new brief. After cleaning the resident's bottom some more, he rolled back the resident, and fastened the brief on both side. In an interview on 07/02/2025 at 10:35 AM, CNA F stated hand hygiene was important to prevent cross contamination and</p>		