

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675231	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Cascades at Jacinto Rehab LP		STREET ADDRESS, CITY, STATE, ZIP CODE  1405 Holland Houston, TX 77029	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644</b></p> <p>Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 2 of 8 residents (Resident #56 and Resident #20) reviewed for privacy in that:</p> <ol style="list-style-type: none"> <li>1. LVN A failed to provide privacy while administering medications via g-tube (a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) to Resident #56 by not closing her privacy curtain on 12/04/2024.</li> <li>2. LVN B failed to provide privacy while administering an IV flush to Resident #20 by administering his IV flush in the middle of the hallway on 12/04/2024.</li> </ol> <p>This failure could place residents at-risk of loss of dignity due to lack of privacy.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #56's face sheet dated 12/5/24 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnosis included gastrostomy infection (complication of gastrostomy tube placement), gastrostomy status (presence of an artificial opening to the stomach), type 2 diabetes, cerebral infarction (stroke), unspecified dementia, altered mental status, post-traumatic stress disorder, and hemiplegia affecting right nondominant side (paralysis of one side of the body).</li> </ol> <p>Record review of Resident #56's quarterly MDS assessment, dated 10/14/2024, reflected the resident had a BIMS score of 0 out of 15 which indicated she had severe cognitive impairment. She had a feeding tube and was dependent on staff for ADL care.</p> <p>Record review of Resident #56's care plan, dated 7/16/24, revealed she required tube feeding related to dysphagia. Interventions/Tasks were that the resident was dependent with tube feeding and water flushes. See MD orders for current feeding orders.</p> <p>In an observation and interview on 12/4/24 at 11:44 a.m. revealed LVN A prepared to administer Resident #56's medication via g-tube. She pulled the curtain to block the open doorway but did not close the privacy curtain between Resident #56 and her roommate. LVN A raised the Resident #56's shirt and began medication administration. The resident's roommate was in the room. LVN A said she forgot to pull the privacy curtain between the residents because Resident #56's roommate gets anxious when the curtain was pulled.</p> <p>(continued on next page)</p>

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/4/24 at 4:21 p.m. the DON said nursing staff should close the door and pull the privacy curtain to provide privacy to the residents. She said privacy was provided for the residents' dignity.</p> <p>2.Record review of Resident #20's face sheet dated 12/5/24 revealed a [AGE] year-old male who admitted on [DATE]. His diagnosis included bipolar disorder, major depressive disorder, mild cognitive impairment, violent behavior and pain.</p> <p>Record review of Resident #20's quarterly MDS assessment, dated 10/14/2024, reflected the resident had a BIMS score of 15 out of 15 which indicated intact cognition. He required ADL assistance from staff.</p> <p>Record review of Resident #20's care plan, dated 11/24/24, revealed he had a current acute infection and was on IV antibiotics due to positive UA. Interventions were to provide treatments as ordered by MD/NP.</p> <p>In an observation and interview on 12/4/24 at 4:48 p.m. in the main hallway revealed LVN B administered Resident #20 an IV flush. There was another resident and staff in the hallway. LVN B said she administered flushes in the hallway or near the nursing station with no problem. She said she did educate the resident on privacy.</p> <p>In an interview on 12/5/24 at 1:17 p.m. the DON said she 99% of the time it was not ok to flush an IV in the hallway. She said the resident should be taken to the room because of privacy and dignity. She said staff should ensure they are in the right environment with no distractions.</p> <p>In an interview on 12/5/24 at 2:17 p.m. the Administrator said it was basic resident rights and dignity for staff to pull the curtain. She also said staff should not provide IV flushes in the hallway for dignity purposes.</p> <p>Record review of facility's policy titled Dignity revised February 2021 revealed 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 .11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>47722</p> <p>Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 3 of 90 days (9/21/24, 9/29/24, and 10/20/24) reviewed for RN coverage.</p> <p>The facility failed to ensure they had RN coverage for at least 8 consecutive hours on 9/21/24, 9/29/24, and 10/20/24.</p> <p>This failure could place residents at risk of missed nursing assessments, interventions, care, and treatment.</p> <p>Findings included:</p> <p>Record review of the staffing sign in sheets for 9/21/24, 9/29/24, and 10/20/24 revealed no RN signed in or on the schedule.</p> <p>Record review of the DON's electronic clock in sheet revealed she worked 4.6hrs on 9/21/24, she didn't work on 9/29/24, and worked 6.93hrs on 10/20/24.</p> <p>In an interview with the DON on 12/4/24 at 10:00am she said an RN must be at the facility for 8 consecutive hours a day. She said the RNs provided direct supervision, filled out incident reports, ran IVs and PICC (thin, flexible tube that's inserted into a vein in the arm and threaded into a large vein above the heart) lines, and ensured everyone was practicing inside their scope of practice. She said that she was usually the nurse who covered if they did not have an RN, but she was not sure what happened on the days in question.</p> <p>In an interview with the Administrator on 12/4/24 at 4:00pm, she said an RN must be in the facility for 8 consecutive hours a day. She said the DON had been working every weekend to provide that coverage, but they just hired an RN for the weekend position. She said the RN started IV lines, provided care for the PICC lines, and provided education. She said if an RN was not at the facility, one of those services would not be able to be performed. The Administrator said there were not any residents who did not receive care that she knew of.</p> <p>Record review of the facility's policy and procedure on Departmental Supervision, Nursing (revised August 2022) read in part: The nursing services department shall be under the direct supervision of a registered or licensed practical/vocational nurse at all times .A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident .</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644</b></p> <p>Based on observation, interview, and record review the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 17% based on 5 errors out of 29 opportunities which involved 2 of 9 residents (Resident #34 and #20) and 2 of 4 staff (MA A and LVN B) reviewed for medication administration.</p> <p>MA A crushed and administered Divalproex DR (a delayed release medication used to treat seizure disorders and mental/mood conditions) and Oxybutynin ER (an extended-release medication used to reduce bladder spasms and treats overactive bladder) to Resident #34 on 12/4/24. Delayed and Extended-release formulations should not be crushed.</p> <p>MA A administered Resident #48's Sertraline (used to treat depression) to Resident #34 on 12/4/24.</p> <p>MA A administered chewable Aspirin instead of enteric coated Aspirin to Resident #34 as ordered by the Physician on 12/4/24.</p> <p>LVN B administered Heparin lock flush (an anticoagulant that prevents blood clots in IV catheters) instead of normal saline flush (used to help prevent IV catheters from becoming blocked) to Resident #20 as ordered by the Physician on 12/4/24.</p> <p>These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health.</p> <p>Findings included:</p> <p>1. Record review of Resident #34's face sheet dated 12/5/24 revealed a [AGE] year old male who admitted on [DATE]. His diagnosis included Alzheimer's disease, major depressive disorder, overactive bladder, other neuromuscular dysfunction of bladder, and persistent mood disorder.</p> <p>Record review of Resident#34's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15, which indicated severe cognitive impairment. He required assistance from staff with ADL care.</p> <p>Record review of Resident #34's care plan dated 9/19/24 revealed he was on anticonvulsant therapy related to mood stabilizer. Interventions were to administer medication per orders. The care plan also indicated resident was at risk for mood impairment related to recent admission, noted with diagnosis of anxiety, bipolar, Alzheimer's, major depressive disorder, persistent mood affective disorder, and insomnia disorder. Interventions were to administer medications as ordered, dated 8/16/24.</p> <p>Record review of Resident #34's Physician orders for December 2024 revealed orders for:</p> <p>Aspirin 81 Delayed Release give 1 tablet by mouth one time a day for anticoagulant ***do not crush**, order date 8/14/24.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Divalproex Delayed Release 125 mg give 1 capsule by mouth three times a day for mood, order date 8/14/24.</p> <p>Oxybutynin Extended Release 10 mg give 1 tablet by mouth one time a day for overactive bladder, order date 8/14/24.</p> <p>Sertraline 25 mg give 1 tablet by mouth one time a day related to anxiety disorder, order date 8/14/24.</p> <p>May crush and cocktail medications as necessary unless contraindicated, order date 8/14/24.</p> <p>In an observation on 12/4/24 at 8:41 a.m. MA A prepared Resident #34's medication for administration. She prepared chewable Aspirin 81 mg, Divalproex DR 125 mg, Oxybutynin ER 10 mg (the pharmacy label read do not crush), and the remainder of his medications. MA A retrieved Resident #48's Sertraline 50 mg and said she would use it for Resident #34. MA A asked LVN C to cut the Sertraline 50 mg in half. LVN C looked at the eMAR and cut the Sertraline 50 mg in half to equal 25 mg and MA A placed it in the cup with Resident #34's medications. MA A said the resident required crushed pills, she crushed all the medication and administered them to the resident.</p> <p>In an interview on 12/4/24 at 9:12 a.m. MA A said she used Resident #48's Sertraline for Resident #34 because she could not find his Sertraline. She said she could use another resident's medication for one time only and then call the pharmacy. She said she was taught in school to never leave a resident without their medication. She said she should check the medication room first for the medication. She said she knew which medication could or could not be crushed because she was experienced. MA A said some medications had permission to be crushed from the MD and that some of the medications did not have an alternative. She said enteric coated medications could not be crushed but she should check with the nurse prior to switching the medication. She said when preparing medication for administration she had to check the 7 rights which included the right patient, dose, time, route, and if the medication could be crushed.</p> <p>In an interview on 12/4/24 at 9:20 a.m. LVN C said she cut the Zoloft (Sertraline) 50 mg in half to equal 25 mg. She said she looked at the eMAR and checked the mg but could not remember if the resident's name on the eMAR matched the name on the blister pack.</p> <p>In an interview on 12/4/24 at 3:57 p.m. the DON said she discussed misappropriation of property with MA A. She said MA A informed her that the pharmacist who trained her said it was better to borrow another resident's medication to ensure the resident received a medication instead of not giving it. The DON said the process at the facility was to notify the nurse, call the MD, put the medication on hold, and see if the medication could be changed to something else. She said MA A could have retrieved the medication from the resident's overstock in the medication room, but she got nervous. She said staff needed to verify the right patient, dose, time, and medication. She said she educated the medication aide on medications that could be crushed and printed out the do not crush list. She said the pharmacy normally sent a label that would indicate if the medication could not be crushed. She said ER and DR formulations were meant to absorb over a specified time and could not be as effective if crushed. She said the medication aide should not decide to change medications, she should notify the nurse who could fix the order. She said medications were paid by the resident's insurance and that could be affected if someone borrowed their medicine.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/5/24 at 2:17 p.m. the Administrator said it was common sense in training for staff to review the directions that were on the MAR and read the information. She said a medication aide was not the physician and she had to follow policy and procedures. She said it was not tolerable to borrow other residents' medications. She said the MA was educated and her expectation was for staff to read and follow the physician orders.</p> <p>2. Record review of Resident #20's face sheet dated 12/5/24 revealed a [AGE] year-old male who admitted on [DATE]. His diagnosis included bipolar disorder, major depressive disorder, mild cognitive impairment, violent behavior, and pain.</p> <p>Record review of Resident #20's quarterly MDS assessment, dated 10/14/2024, reflected the resident had a BIMS score of 15 out of 15 which indicated intact cognition. He required ADL assistance from staff.</p> <p>Record review of Resident #20's care plan, dated 11/24/24, revealed he had a current acute infection and was on IV antibiotics due to positive UA. Interventions were to provide treatments as ordered by MD/NP.</p> <p>Record review of Resident #20's Physician Orders for December 2024 indicated an order for: Sodium Chloride 0.9% flush 10 mL every shift for maintenance, order date 11/30/24. There were no orders for Heparin lock flush.</p> <p>In an observation and interview on 12/4/24 at 4:48 p.m. in the main hallway LVN B administered heparin lock flush 5 mL to one of Resident #20's lumens (a port through which IV treatments and blood transfusions can be given). LVN B attempted to flush the other lumen with Heparin lock flush but was unable to because it was clogged. LVN B placed one full flush in her pocket and discarded the empty one in the trash. LVN B said the resident was prescribed normal saline flush and did not realize the flushes were heparin lock flush. She retrieved the full flush from her pocket and this Surveyor retrieved the empty flush from the trash and both flushes were verified as Heparin flush lock 50 USP units/5 mL with LVN B. She said the ADON gave her the flushes from her pocket. She said the difference between the heparin lock and saline flush was that heparin was used for cardiac patients. She said she was pretty sure there were risks to administering heparin lock flush, but she would have to familiarize herself with them. She said she would monitor Resident #20 for side effects.</p> <p>In an interview on 12/4/24 at 5:01 p.m. the ADON said she did not give LVN B heparin lock flushes.</p> <p>Record review of LVN B's statement dated 12/4/24 at 5:54 p.m. read in part, I, [LVN B], in haste, accidentally administered 5 mL of Heparin lock flush to one port of his PICC line to left upper arm. Resident was immediately reassessed and PICC line was flushed with 10 mL of saline flush. Vital signs were within normal limits and resident reported no signs or symptoms cardiac issues.</p> <p>In an interview on 12/5/24 at 8:56 a.m. Resident #20 said he did not have any bleeding or bruising, and the facility removed his IV access.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/5/24 at 9:04 a.m. the DON said she notified Resident #20's MD about the heparin lock flush incident. She said the MD said the heparin lock flush was ok to give and there was no harm done. The MD informed her to observe for signs of bleeding and remove the PICC line. She said there was no direct scientific correlation that was harmful because heparin and saline lock were interchangeable.</p> <p>In an interview on 12/5/24 at 9:06 a.m. the ADON said LVN B informed her that she obtained the heparin lock flush from the back of the nursing cart.</p> <p>In an interview on 12/5/24 at 12:06 p.m. Resident #20's MD said it was the standard of care in the hospital to flush PICC lines with heparin. He said it was considered acceptable in the nursing home to flush with saline, but the heparin lock flush had a minute dose and would not cause anything. He said it would keep the line open but had no systemic effect. He said it was a medical error and the resident was originally prescribed normal saline flush, but the error caused no harm or risk to the patient. He said the facility notified him and he ordered for the picc line to be removed and there was no deviation from normal care.</p> <p>In an interview on 12/5/24 at 1:17 p.m. the DON said LVN B should have check the name of the flush against the MAR. She said the nurse should also know that heparin was blue, or orange and the normal saline was black. She said she did not know where the nurse retrieved the heparin flush from, and they could not find any more in the facility. She said nursing staff should verify the 5 rights of medication administration which included the right patient, dose, time, and medication. She said there was no risk of using heparin instead of the saline because all IVs in the hospital were flushed with heparin. She said it could be used interchangeably if there was a Physicians order. She said the LVN should have pulled the correct flush and could not answer why she pulled the heparin. She said the DON was ultimately responsible for ensuring the resident received the right medication, but the administering staff was immediately responsible for accuracy. She said she completed skills check off with LVN B. (A skills check is a practical list that details the skills an employee is required to perform and the level of performance that is expected for each skill).</p> <p>In an interview on 12/5/24 at 2:17 p.m. the Administrator said nursing staff should be able to check for the proper medication, right patient, and right process.</p> <p>Record review of the facility's Crushing Medications policy dated April 2018 read in part, .Medication shall be crushed only when it is appropriate and safe to do so, consistent with physician orders .2. The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long acting or enteric coated medications) .</p> <p>Record review of Medication Crushing Guidelines dated 2001 provided by the facility read in part, .the rationale for not crushing some medications include: .D. Timed Release Tablets are designed to release medication over a sustained period, usually 8 to 24 hours. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases. In either case these tablets should not be crushed</p> <p>Record review of the undated document Medications not to be crushed provided by the facility revealed Divalproex Sodium: DR, ER and Oxybutynin ER were listed.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Administering Medications policy dated April 2019 read in part, .Medications are administered in a safe and timely manner and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame . 9. The individual administering medications verifies the resident's identity before giving the resident his/her medications . 10. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication . 26. Medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing Services.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644</b></p> <p>Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 8 residents (Resident #20 and #56) reviewed for infection control.</p> <p>-LVN A did not wear appropriate PPE when administering medication via peg-tube care (PEG tubes allow you to receive nutrition through your stomach) to Resident #56 who was on enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes) on 12/4/24.</p> <p>-LVN A de-clogged (remove or clear a blockage) Resident #56's g-tube using an oxygen key that was retrieved from her pocket on 12/4/24.</p> <p>-LVN B did not wear appropriate PPE when administering an IV picc line flush to Resident #20 on 12/4/24 who was on enhanced barrier precautions per facility protocol and care plan.</p> <p>These failures could place residents at risk of infections.</p> <p>Findings included:</p> <p>1. Record review of Resident #56's face sheet dated 12/5/24 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnosis included gastrostomy infection (complication of gastrostomy tube placement), gastrostomy status (presence of an artificial opening to the stomach), type 2 diabetes, cerebral infarction (stroke), unspecified dementia, altered mental status, post-traumatic stress disorder, and hemiplegia affecting right nondominant side (paralysis of one side of the body).</p> <p>Record review of Resident #56's quarterly MDS assessment, dated 10/14/2024, reflected the resident had a BIMS score of 0 out of 15 which indicated she had severe cognitive impairment. She had a feeding tube and was dependent on staff for ADL care.</p> <p>Record review of Resident #56's care plan revised on 8/10/24 revealed she required enhanced barrier precautions due to IV antibiotics (resolved) peg tube feedings. Interventions included: staff will wear gloves and gown (per protocol) to provide high contact care activity to include dressing, bathing/showering, transferring, hygiene, changing linens, changing briefs, assist with toileting, device care or use (PICC/central line, catheter, feeding tube, trach, vent), wound care. Her care plan revealed she required tube feeding related to dysphagia. Interventions/Tasks were that the resident was dependent with tube feeding and water flushes. See MD orders for current feeding orders, dated 7/16/24.</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>In an observation and interview on 12/4/24 at 11:44 a.m. LVN A prepared and began the medication administration process for Resident #56's via g-tube. She donned (put on) gloves but did not don a gown. There was a sign on Resident #56's door that read, STOP Enhanced Barrier Precautions, everyone must: clean their hands, including before entering and when leaving the room. Providers and Staff must also wear gloves and gown for the following high contact resident care activities . device care or use . feeding tube . There was also PPE on the door. LVN A said the PPE had been on the resident's door for a while, but she did not have wounds or MRSA. LVN A checked for placement and residual and then started administration via g-tube with a water flush. The water flush would not drain through the tube, LVN A used the syringe to push the water into the tube to try to declog it. After that she retrieved her keys from her pocket and used an oxygen key to strip (stretch the tube and try to dissolve the pieces) the g-tube plastic multiple times. After alternating between stripping the tube with the oxygen key and pushing the water with the syringe, LVN A was able to declog Resident #56's tube and proceed with administering the medications.</p> <p>In an interview on 12/4/24 at 12:06 p.m. LVN A said Resident #56 used to have a roommate with wounds who passed away and that was why the enhanced barrier precaution sign was on her door. She said the hospice providers would come in and wear PPE when providing the resident with a shower. She said gowns were not required when caring for g-tubes. She said she was in serviced on enhanced barrier precautions one month ago and the information provided on the door sign was new. She said she used an oxygen key to strip and declog Resident #56's g-tube. She said she was unsure if using the oxygen key was allowed but that was how she unclogged the tube. She said to maintain infection control she only used the key on the plastic portion on the outside of the tube, not near the resident ports.</p> <p>In an interview on 12/4/24 at 4:14 p.m. the DON said enhanced barrier precautions (EBP) required staff to use gloves and gown and was like contact isolation. She said she educated staff that EBP was for residents with g-tube, a wound, and was to prevent passing infections on to another resident.</p> <p>In an interview on 12/5/24 at 1:17 p.m. the DON said an oxygen key retrieved from the pocket should not be used on a g-tube because it could be infected with anything. She said infection or bacteria could be introduced to the patient.</p> <p>2.Record review of Resident #20's face sheet dated 12/5/24 revealed a [AGE] year-old male who admitted on [DATE]. His diagnosis included bipolar disorder, major depressive disorder, mild cognitive impairment, violent behavior, and pain.</p> <p>Record review of Resident #20's quarterly MDS assessment, dated 10/14/2024, reflected the resident had a BIMS score of 15 out of 15 which indicated intact cognition. He required ADL assistance from staff.</p> <p>Record review of Resident #20's care plan, dated 11/24/24, revealed he had a current acute infection and was on IV antibiotics due to positive UA. Interventions were to provide treatments as ordered by MD/NP, Enhanced Barrier Precautions (Novel MDRO)(per protocol): use gloves and gown to provide high-contact care. Use face mask if there is a risk of splash or spray. Infection control precautions per CDC guidelines for acute infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675231	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Cascades at Jacinto Rehab LP		STREET ADDRESS, CITY, STATE, ZIP CODE  1405 Holland Houston, TX 77029	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation and interview on 12/4/24 at 4:48 p.m. in the main hallway revealed LVN B administered Resident #20 an IV flush. She donned gloves but did not have on a gown. She said the resident did not require any special PPE, only standard gloves. She said EBP was for high-risk residents who had infections such as MRSA and CDIFF. She said Resident #20 was not on precautions.</p> <p>In an interview on 12/5/24 at 1:17 p.m. the DON said full PPE including a face mask, gown, and gloves were required for Resident #20 because of his IV site. She said the resident had an EBP sign on his doorway.</p> <p>In an interview on 12/5/24 at 2:17 p.m. the Administrator said the facility provided monthly training on enhanced barrier precautions and it should have been honored by using the proper PPE and protocol.</p> <p>Record review of the facility's Enhanced Barrier Precautions policy revised August 2022 read in part, . Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents . 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. A. gloves and gown are applied prior to performing the high contact resident activity . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .g.device care or use (central line, urinary catheter, feeding tube, .) 5. EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.</p> <p>Record review of the facility's Administering Medications policy revised April 2019 read in part, .25. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable .</p>		