STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675396	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	1100 Galveston Laredo, TX 78040

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49157 Based on observation, interview, and record review, the facility failed to post the results of the most recent survey of the facility in a place readily accessible to residents, family members, and legal representatives for ten (Resident # 3,28,37,42,48,50,55,57,64, and 169) of ten residents interviewed for resident rights. The facility failed to ensure the most recent survey results were readily accessible to residents, family members, and legal representatives. This failure could place residents, family members, and legal representatives at risk of not being able to fully exercise their right to be informed of the facility's survey results and citation history. Findings included: In an interview on 06/26/24 10:02 AM in a group meeting with ten residents (Resident # 3,28,37,42,48,50,55, 57,64, and 169), all ten residents stated they were not aware of nor had they seen a previous survey binder. Observation on 06/26/24 at 11:00am revealed the survey results book was not located in the common areas of the facility nor was there a sign that indicated where the survey results book could be found. In an interview on 06/26/24 at 11:13 AM, the ADON stated the survey results were posted up front. The Admin and the ADON went up to the front lobby and searched for the survey binder. The ADON located the binder in a drawer of the unattended reception desk. (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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 06/26/24 at 11:24 AM of the survey binder that was located in the unattended reception desk drawer revealed a 1/2 inch white binder with an 8 1/2 x 11 inch piece of paper slid in the front cover that had Full Book Survey April 2023 printed on it. Pages 1-3 were a letter a dated 04/24/23 from Texas Health and Human Services to the Administrator that stated in part the HHSC had conducted a health investigation on 04/06/23, and the survey found that the facility did not meet state licensure requirements and was not in substantial compliance with federal participation requirements. There was no information on what violations/deficiencies were cited. Pages 4-7 were a letter dated 03/04/22 from Texas HHSC that stated in part that the HHSC had conducted a Health and Life Safety Code Recertification Survey and a Health Complaint Investigation on 02/17/22 and the Life Safety Code survey found that the facility did not meet state licensure requirements and was not in substantial compliance with federal participation requirements and that the Health survey found that the facility was in substantial compliance with federal participation requirements. Page 8 was the CMS 2567 Form that had survey completion date 02/18/22 and stated in part that the facility was in compliance with federal requirements for long term care. Page 9 was the HHSC 3724 Form that had a survey completion date 02/18/22 and stated in part that the facility was in compliance with state licensure requirements. The following 12 pages listed the Life Safety Code violations. There was no policy provided by the facility regarding the availability of survey results to residents, family members, or legal representatives.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy for 1 of 9 residents (Resident #32) reviewed for privacy. The facility failed to ensure RN A provided privacy by closing Resident #32's door or privacy curtain during administration of a subcutaneous insulin injection into Resident #32's abdomen on 06/25/2024 at 10:59 AM. This failure could place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and a diminished quality of life. The findings included: Record review of Resident #32's face sheet dated 06/26/2024 reflected a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE]. Pertinent diagnoses include Type 2 Diabetes Mellitus (chronic condition that occurs when the body does not produce enough insulin or cells do not respond to insulin properly), Generalized Anxiety Disorder (feelings of extreme worry or nervousness even when there is little or no reason to have them), and Alzheimer's Disease (progressive brain disease that causes a mental decline affecting the quality of daily living). Record review of Resident #32's MDS dated [DATE] reflected a BIMS score of 11 (moderate impairment) Record review of Resident #32's care plan dated 06/26/2024 reflected Resident #32 had Diabetes Mellitus with daily insulin injections. Interventions listed include, but were not limited to, administering diabetes medication as ordered by doctor and observe/document for side effects and effectiveness, encourage resident to practice good general health practices, and compliance with treatment regimen. Record review of Resident #32's order summary report dated 06/26/2024 revealed an active order for Novolog FlexPen Solution (Insulin). During an observation of RN A performing medication administration on 06/25/2024 at 10:59 AM, RN A measured the blood glucose and gave a subcutaneous Novolog insulin injection to Resident #32 in his abdomen in his room while Resident #32 was sitting in his wheelchair. After RN A walked into the room, the door was left wide open, and throughout the medication administration, the privacy curtain was never utilized. No other residents or facility staff were present in the room at that time. RN A lifted Resident #32's shirt to expose Resident #32's skin and to have an exposed site to give the insulin injection. Resident #32 was in full view from the hallway by any individual walking by his room throughout the blood glucose test and insulin administration. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN A on 06/25/2024 at 1:34 PM, RN A stated she has given insulin injections to residents in common areas before. RN A stated the DON and ADON have told her to not give injections in common areas. RN A stated some residents do not listen to her, and she struggles with balancing giving them the medication they need and protecting their privacy. RN A stated the door was open during the entire time she was in Resident #32's room for the blood glucose test and insulin injection. RN A stated she did not know she needed to shut the door or use the privacy curtain when administering insulin injections. RN A stated that residents may get agitated or it could make them feel more vulnerable and destroy rapport if their privacy was not protected. In an interview with the DON on 06/26/2024 at 12:56 PM, the DON stated that residents should be in their rooms when being administered any medication. The DON stated that in order to protect the privacy of the residents, their doors, curtains, and possibly blinds should be closed depending on what administration or procedure was taking place. The DON stated that it was not appropriate to give insulin injections to residents in their rooms without first closing the door or privacy curtain. The DON stated that not providing residents with privacy could impede on the resident's dignity and cause negative emotional effects. The DON stated that he has spoken to staff about administering medications with the appropriate protections for privacy, but does not remember a specific in-service. Record review of the facility's policy titled Medication Administration dated 10/24/2024 stated: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 7. Provide privacy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 46038 Based on observation, interview, and record review, the facility failed to ensure that the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, for three residents (Resident #14, Resident #30, and Resident #49) of 24 residents whose care plans were reviewed, in that: 1) Resident #14's comprehensive care plan was not revised after being prescribed Albuterol Sulfate Inhalation Nebulization Solution on 5/1/24 to reflect a respiratory plan of care. 2) Resident #30's comprehensive care plan was not revised after her quarterly safe smoking evaluations (assessments) changed. 3) Resident #49's comprehensive care plan failed to include he was a smoker. This failure could place residents at risk for inadequate care. The findings included: 1) Resident #14 Record review of Resident #14s face sheet dated 6/24/24 reflected a [AGE] year-old-female with an original admitted [DATE]. Diagnoses included cerebral infarction (stroke that occurs when a blood vessel that supplies the blood to the brain is blocked), pneumonia (inflammatory condition of the lung(s) primarily affecting the small air sacs), and respiratory failure. Record review of Resident #14's MDS dated [DATE] reflected Resident #14 had an active diagnosis of respiratory failure and pneumonia with the use of oxygen therapy. Record review of Resident #14's care plan dated 4/30/24 and revised on 5/13/24 did not reflect any respiratory condition or the use of Albuterol Sulfate Nebulization Solution. Record review of Resident #14's physician orders dated 5/1/24 stated: Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 1 application inhale orally via (by way of) nebulizer every 6 hours for Anti-asthmatic and Bronchodilator agents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/26/24 at 1:08 pm the DON stated an order for albuterol should have been care planned for Resident #14 since Resident #14 was on respiratory treatments. The DON stated the care plan is necessary, so staff can monitor the goals of Resident #14 and access if the interventions need to be updated or revised. The DON stated the MDS Coordinators are the ones to audit care plans after the initial care plans have been entered by either charge nurses or administration. The DON stated he and the ADON oversee that care plans are up to date and accurate. The DON stated Resident #14's care plan was overlooked and missed. In an interview on 06/26/24 at 1:20pm the ADON stated Resident #14's care plan should have been updated to reflect the order of albuterol since it is person centered. The ADON stated it she and the DON oversee that care plans are up to date and accurate but Resident #14's care plan was missed. The ADON stated by not have Resident #14's respiratory plan of care updated, staff would not be aware of the goals and interventions if there were complications. In an interview on 06/26/24 at 2:18pm MDS Coordinator D stated care plans are reviewed and updated quarterly by both MDS Coordinators and the DON and the ADON are the ones to update acute changes in a resident's plan of care. MDS Coordinator D stated an order list, reflecting new resident orders, are printed out every business day and checked to see if there were any updates that need to be made on a resident's care plan. MDS Coordinator D stated it was an oversight and could not give an explanation on why Resident #14's change in medication was missed in the care plan. 2) Resident #30 Record review of Resident #30s face sheet reflected a [AGE] year-old-female with an initial admitted [DATE] and a re-admitted d 12/30/20. Diagnoses included chronic obstructive pulmonary disease (COPD), Heart disease, Alzheimer's, dementia, diabetes, schizophrenia, psychosis, nicotine dependence, high blood pressure, and need for assistance with personal care. Record review of Resident #30's MDS dated [DATE] reflected Resident #30 had a BIMS of 1, indicating severe cognitive impairment. Resident #30 had unclear and slurred or mumbled speech and had a limited ability to make concrete requests. She responded to adequately to simple, direct communication only. She had impaired vision. She was ambulatory and required substantial assistance with oral care, moderate assistance with toileting and showering, supervision with dressing, and set-up assistance with eating. She was incontinent of bladder and occasionally bowel. She had an active diagnosis of cardiorespiratory conditions. Record review of Resident #30's care plan dated 05/06/24 and revised on 11/02/22 reflected she was a smoker. Interventions included wear an apron when out smoking initiated 09/25/23, and she required supervision while smoking initiated 12/04/20 and revised on 09/27/21. Next review date 08/04/24. Record review of Resident #30's quarterly safe smoking assessments dated 02/05/24 indicated she required supervision only and was no longer required an apron. This was not reflected in the most recent care plan dated 05/06/24. Observation of smokers in the designated smoking area on 06/26/24 at 1:30 pm revealed 4 of 7 smokers were smoking. Resident #30 was not wearing an apron. Resident #49 was smoking. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON and ADON on 06/26/24 at 1:17 pm revealed the care plans were updated immediately after a change. The DON stated they go over changes in their daily morning meetings with all department heads. They stated safe smoking evaluations (assessments) should be done quarterly and reflected and updated in the care plans as soon as they found out. The DON stated safe smoking evaluations (assessments) were supposed to be done on admission and quarterly. They both stated smoking should be care planned, and Resident #30's care plan was not complete regarding whether she should wear an apron, but it was not documented anywhere. They both stated the safe smoking evaluations (assessments) were done to determine the level of supervision required, and that should be care planned. They stated Resident #30's care plan had not been updated as it should have been. They stated the social worker attended the daily morning meetings and they were responsible for the work they input. The DON stated everyone was doing something different and they were working on it. The DON stated staff should have been updating their own care plans-when there were changes or updates needed. The DON stated the MDS nurses had their own system. The DON stated he only updated the care plans when a situation presented itself. 3) Resident #49 Record review of Resident #49s face sheet reflected a [AGE] year-old-male with an initial admitted [DATE] and a re-admitted d 05/07/24. Diagnoses included heart disease, diabetes, high blood pressure, malnutrition, amputations of his right leg below the knee and his left leg above the knee and need for assistance with personal care. Record review of Resident #49's MDS dated [DATE] reflected Resident #49 had a BIMS of 8, indicating moderate cognitive impairment. He was moderately hard of hearing and had visual impairment. He was dependent on staff for toileting hygiene and required substantial assistance with bathing, moderate assistance with dressing, supervision with dressing, and set-up assistance with eating and oral hygiene. He was occasionally incontinent of bladder and frequently incontinent of bowel. He had an active diagnosis of cardiorespiratory conditions. Record review of Resident #49's care plan dated 05/21/24 had initiation dates of 01/31/24 and revisions on 05/23/24. Smoking was not reflected in his care plan on any date. Record review of Resident #49's quarterly safe smoking assessment dated [DATE] documented cognitive loss, visual deficits, and dexterity problems. He could light his own cigarette and required supervision when smoking. Interview with the DON and ADON 06/26/24 at 1:17 pm revealed the care plans got updated immediately after a change. They stated smoking should be care planned, and Resident #49's care plan was not complete. They said Resident #49 did not start smoking until recently, but it was not documented anywhere. Record review of Care Plan Upon Status Change policy dated 10/24/24 stated: Policy The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedures for reviewing and revising the care plan when a resident experiences a status change: b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified. f. Care plans will be mortified as needed by the MDS Coordinator or other designated staff member. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44748 Based on observation, interview, 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 sanitation. 1. The facility failed to ensure juice dispenser nozzles were sanitary. 2. The facility failed to ensure equipment was clean and sanitized. 3. The facility failed to ensure the kitchen staff was following their policies. These failures could place residents at risk of foodborne illnesses. Findings included: Observation and initial tour of the kitchen on 06/24/24 beginning at 12:00 pm revealed 2 of 2 juice nozzle had a thick, sticky red substance that was congealed on and in the nozzles. Inside the nozzles, the same thick, sticky, congealed red substance was stuck to them. In an interview with the DA on 06/24/24 at 12:15 pm, she stated the juice nozzle were cleaned only at night. She stated the juice nozzle always looked like that, especially over the last four months. She stated there was a cleaning schedule the kitchen staff followed. In an interview with the DM on 06/24/24 at 12:20 pm, he stated he had the entire juice machine replaced, but the juice nozzle continued to become congealed over the last 4-6 months. He stated he called the man who serviced the juice machine, and he told him to call the company. He stated the procedure was that he would put work orders into the facility's electronic work order system, and the MS was supposed to call the company for the juice machine, but the company never came or responded. He stated he would change the cleaning schedule to daily cleaning for the juice nozzle. He stated bacteria could grow in the nozzles and make the residents sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the MS by way of an interpreter HR on 06/26/24 at 2:40 pm, he stated he did not know how to pull reports from the facility's electronic work order system. He stated sometimes the kitchen staff notified him regarding the juice machine/juice nozzle, but they did not enter the problem(s) into the facility's electronic work order system. When asked how many times the kitchen staff had notified him about the juice machine/juice nozzle in the last four to six months, he stated the company from the juice machine came regularly to check on it and he thought it was once a week, but he needed to check with the DM. He stated the machine was replaced on 10/01/23. He stated the company that checked the juice machine/juice nozzle once a week told him they were there to regulate the juice because sometimes they said it (the juice) was too condensed. He stated kitchen staff had been complaining about the juice machine/juice nozzle for two to three weeks and the company that checked the juice machine/juice nozzle would have to regulate the juice every time they were there. He stated he did not know why the juice machine/juice nozzle was not getting fixed, and he guessed the dietary aid was not notifying the company. He stated the company from the juice machine was not allowing him to touch the machine too much and when there was an issue, the company from the juice machine was to come in and fix it. He stated he had seen the dirty nozzles on the juice nozzle and shook his head side to side indicating no when asked if the nozzles looked like they had been cleaned daily. He stated the DM should be in charge of contacting the company from the juice machine. He stated he himself had never contacted the company for the juice machine. Then he stated the people from the juice machine company that came once a week did not look at the machine because they only delivered juice once a week, unless they let them know there was something wrong, they would look at it, but typically, they come in and delivered or change the juices. Record review of the cleaning schedules dated 01/01/24-06/24/24 revealed all spaces filled, indicating cleaning had been done regularly on kitchen equipment, but there was no space labeled juice nozzle or juice machine. Record review of the electronic work order system requests revealed Work order #6393 dated 03/14/24 Check Juice Machine the work order was created by the DM on 03/14/24 at 10:39 am and closed by the MS on 03/14/24 at 1:50 pm. This was the only work order in the facility's electronic work order system regarding the juice machine from 02/01/24-05/30/24. Record review of in-services for kitchen staff: 12/18/23-Use Oven Mitts, pay attention to Surroundings, 01/18/24-Tray line Temperatures, food receipts, eating in the kitchen, dish machine logs. 06/25/24-Level 4 spoon/fork test, 06/26/24-Juice machine cleaning; how to and signing cleaning log. Record review of the facility kitchen policy titled, Cleaning Schedules dated 10/01/18 revealed under Policy: The facility will maintain a cleaning schedule prepared by the nutrition and food service manager and followed by employees as assigned in order to ensure that the kitchen is clean and free of hazards. Record review of the facility kitchen policy titled, Coffee machines and Juice Machines revised 06/01/2019 revealed under Policy: The facility will maintain coffee machines and juice machines in a clean and sanitized condition to minimize the risk of food hazards. Coffee and juice machines will be cleaned once per day. Under Procedure: 2. Juice machines should be cleaned following the manufacturer's instructions. The nozzle will be cleaned daily. References: TAC 554.1111 (b) The facility must store, prepare, and serve food under sanitary conditions, as required by the Texas Department of State Health Service sanitation requirements.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on interview and record review, the facility nursing staff failed to demonstrate competencies and skills sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care, for one resident (Resident #14) of 24 residents reviewed, in that: -The facility failed to revise orders for Resident #14's code status from full code to DNR after receiving a DNR form from Resident #14's family member on [DATE]. Resident #14 had both CPR and DNR reflected in their orders. This deficient practice could affect residents who require care and monitoring and place them at risk of not receiving the care and services to meet their needs. The findings included: Record review of Resident #14s face sheet dated [DATE] reflected a [AGE] year-old-female with an original admitted [DATE]. Diagnoses included cerebral infarction (stroke that occurs when a blood vessel that supplies the blood to the brain is blocked), pneumonia (inflammatory condition of the lung(s) primarily affecting the small air sacs), and respiratory failure. Record review of Resident #14's care plan dated [DATE] and revised on [DATE] stated: As per responsible party I know Resident #14 was dealing with all sorts of health issues, she had a stroke in the past, at her age, her health will continue to decline so, the decision is no- CPR/ DNR. Interventions included: If resident has a cardiac arrest, do not call 911. Notify physician/responsible party and follow physician orders after notification. Record review of Resident #14's physician orders dated [DATE] stated: -Full Code as evaluated by social worker and instructed nurse to place as so until further notice. No directions specified for order. -DNR (Do Not Resuscitate) No directions specified for order. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 12:56pm the DON stated charge nurses were in charge of in putting initial orders for the resident and the DON and the ADON oversaw that orders were inputted correctly. The DON stated Resident #14's orders should not reflect both full code and DNR status. The DON stated resident changes were discussed daily during morning meetings. The DON stated at times he was out on the floor working and unable to attend all morning meetings and, in that case, either the SW, MDS, or anyone who attended the morning meeting were supposed to communicate and inform him of any changes that had occurred. The DON stated he was not informed of Resident #14's code status change and that it was overlooked. The DON stated Resident #14's code status would be corrected and updated immediately. The DON stated by having both code status for Resident #14 could make it hard to determine what actions to take in case of an emergency. MDS and medical records take part in looking for discrepancies and notifying DON and ADON. In an interview on [DATE] at 1:22pm the ADON stated every morning Monday through Friday resident orders were checked and audited for accuracy. The ADON stated whenever there was a change in code status, it was usually discussed in morning meetings and the ADON and DON made the changes needed. The ADON stated sometimes she and the DON could not attend morning meetings if they were needed out on the floor and believed that was how Resident #14's code status was not accurate. The ADON stated it was important Resident #14's code status was accurate as to avoid confusion on what procedures to take in case Resident #14 had an emergency. In an interview on [DATE] at 02:28pm MDS Coordinators E stated resident orders were reviewed in morning meetings to make sure care plans matched the orders. MDS Coordinators E stated if there was a discrepancy in the order, she or the other MDS Coordinator would alert the DON or ADON of the error so it could be corrected. MDS Coordinator E stated Resident #14's code status was overlooked. In an interview on [DATE] at 03:07 PM, the SW stated, once the initial advance directives were completed by her, then it was communicated to the charge nurses or to the DON/ADON to update in their computer system. The SW stated during the time Resident #14's code status was changed; she was out on leave and there was two other SW's covering for her during that time. The SW stated she did not know who the other SW's were as they were from different companies. The SW stated when a code status was changed, medical records was notified about a resident's code status either through morning meetings or through communication by administration and then updated in their computer system. The SW stated if a resident's code status was not entered, the SW would notify the DON/ADON or the charge nurses so it could be inputted in their system. The SW stated some residents were audited for code status when she returned to work but Resident #14 was missed and was an oversight. The SW stated there was no communication done once she returned from vacation and was unsure what was done or not done during her absence. The DON was asked by this surveyor for a policy on code status/ Following physician's orders multiple times and no policy was provided during the duration of the survey.

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	675396	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laredo South Nursing and Rehabilitation Center	1100 Galveston Laredo, TX 78040

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observation, interview, and record review, the facility failed to maintain a comprehensive infection prevention and control program that included employing proper signage on the doors of resident's rooms to prevent the transmission of communicable diseases and infections for 2 of 28 residents (Resident #51 and Resident #19) reviewed for infection control. 1. The facility failed to place a readily visible EBP sign on the door of Resident #51 who was actively on EBP which requires an individual to don gown and gloves when performing patient care on 06/24/2024 at 11:35 AM. 2. The facility failed to place a sign on Resident #19's room door who was being tested for C. Diff(clostridioides difficile- a type of bacteria that is contagious and causes diarrhea and inflammation of the colon and can be life threatening) on 06/24/24. PPE such as gown and gloves was required to prevent cross contamination when providing care for residents with C-Diff. This failure could place residents at risk of cross contamination, infection, and illness. The findings included: 1) Record review of Resident #51's face sheet dated 6/24/2024 reflected a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE]. Pertinent diagnoses include Functional Quadriplegia (condition that causes complete immobility due to a severe physical disability or frailty, not due to spinal cord damage or stroke), Heart Disease (general term for many conditions that affect the heart's structure and function), and Respiratory Failure (condition in which it is difficult to breathe on your own). Record review of Resident #51's MDS dated [DATE] reflected a BIMS score of 6 (severe impairment). Record review of Resident #51's care plan dated 06/24/2024 reflected Resident #51 required tube feeding. Interventions listed include, but were not limited to, the resident needs assistance with tube feeding and water flushes. During an observation outside Resident #51's room on 06/24/2024 at 11:35 AM, it was noted that assorted PPE was placed in the pockets of an apron hanging on the door. Other PPE was noted in a drawer just outside the room. No sign was visible from the hallway advising visitors or staff to wear PPE before entering Resident #51's room or when performing care on Resident #51. Further observation found that there was a sign in the apron hanging on the door that read STOP SEE NURSE BEFORE ENTERING. The apron hanging on the door had folded over itself, obscuring this sign from view unless the apron was physically moved by an individual. In an interview with MA on 06/24/2024 at 11:41 AM, MA stated that Resident #51 was on EBP. MA stated that the proper PPE to wear before providing care for Resident #51 was a gown and gloves. MA stated that the STOP SEE NURSE BEFORE ENTERING sign was not visible from the hallway before entering the room. MA stated that because the sign was not readily visible, anyone could walk in the room and not put on PPE before interacting with Resident #51. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN A on 06/24/2024 at 3:38 PM, RN A stated that Resident #51 was on EBP, and that gown and gloves were required when providing care for EBP residents. In an interview with the DON on 06/26/2024 at 12:56 PM, the DON stated that Resident #51 was currently on EBP. The DON stated that gown and gloves were required when providing care and when touch was necessary. The DON stated that an orange EBP sign should be posted on all doors of residents that are on EBP. The DON stated that if the signs are not on the door, individuals could walk in the room and potentially spread infection to or from the resident. The DON stated that, for example, all residents with a PEG tube (surgery to place a tube directly into stomach), wound, tracheostomy (surgical procedure that creates an airway by making and incision in the neck), and receiving intravenous fluids are placed on EBP. The DON stated they have had several in-services on proper EBP care but could not remember any specific dates. The DON stated that the facility does not have a specific policy on EBP, but that they go by the guidance provided from the CDC. In an interview with CNA D on 06/26/2024 at 4:19 PM, CNA D stated that any resident with certain conditions such as tracheostomies, catheters and PEG tubes are on EBP. CNA D stated that she knows which rooms require EBP because they have a sign on the door and PPE outside the room. CNA D stated that the ADON puts the EBP signs on the door. In an interview with LVN E on 06/26/24 at 4:19 PM, LVN E stated that any resident with certain conditions such as tracheostomies, catheters and PEG tubes are on EBP. LVN E stated that he knows which rooms require EBP because they have a sign on the door and PPE outside the room. LVN E stated that the ADON puts the EBP signs on the door. In an interview with the ADON on 06/26/2024 at 5:05 PM, ADON stated it was her responsibility to ensure all residents that require EBP have the appropriate sign on the door and it was plainly visible. 2) Record review of Resident #19's face sheet indicated a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Diagnoses included diabetes, high blood pressure, Alzheimer's disease, muscle wasting and atrophy (decrease in muscle size), lack of coordination, and need for assistance with personal care. Record review of Resident #19's annual MDS indicated she had a BIMS score of 5 (severe cognitive impairment). Record review of Resident #19's care plan on 06/25/24 indicated that she required extensive staff assistance with all ADLs and that she was incontinent of bowel and bladder. Observation on 06/25/24 at 09:39 AM revealed there was no sign on Resident #19's door that indicated the resident was on isolation precautions for possible c. diff. Record review of Resident #19's order summary on 06/25/24 at 09:49 AM revealed that she had a stool sample sent to the laboratory on 06/24/24 at 08:21 AM to be tested for c. diff. That order summary did not include an order for c. diff precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/25/24 at 10:32 AM, the ADON stated when someone has a c. diff test pending, the resident should be placed on isolation precautions. The ADON stated she did not know why Resident #19 was not placed on isolation precautions. Record review of Resident #19's order summary report on 06/25/24 at 10:49 AM revealed a telephone order dated 06/25/24 to place resident on isolation precautions for possible C. Diff. Observation on 06/25/24 at 1:36 PM revealed a PPE holder hanging on Resident #19's door. Along with gowns and gloves, the holder had a sign that read, STOP SEE NURSE BEFORE ENTERING and a canister of disinfecting wipes, however it was not bleach wipes and the label on the canister did not indicate the wipes were effective against c. diff. In an interview on 06/25/24 at 1:43 PM, the MA stated that c. diff precautions meant contact isolation: gown, gloves, mask, shoe covers, and wash hands with soap and water when someone went into and out of the resident's room. The MA stated there were no other precautions that she could think of and did not state that bleach wipes were required for disinfection of non-porous surfaces in the resident's room. The MA stated if they did not wash hands or use PPE, it could cause the c. diff to be spread to other residents. The MA stated that c. diff could cause dehydration and possible death. The MA stated they did in service modules on the computer every month, but could not remember the last time she did actual contact, c. diff, droplet, or airborne precaution training. The MA stated she had hand washing and EBP in service in the last month. In an interview on 06/25/24 at 1:51 PM, CNA F stated c. diff precautions included gown, gloves, mask, and hand washing. CNA F stated that the red or blue bleach wipes were supposed to be used but that the ADON had them and did not give them to her. CNA F stated she did yearly in services on the different types of isolation precautions. In an interview with LVN C and RN B on 06/25/24 at 2:07 PM, LVN C stated Resident #19 was on isolation precautions because she had possible c. diff. LVN C stated c. diff precautions included gown, gloves, shoe covers, and masks. RN B stated that hand washing was to be done after resident care. LVN C stated that any equipment used for or on Resident #19 was to stay in the room with her to be used only on her. LVN C stated the equipment was to be disposed of after Resident #19 was no longer on isolation precautions to prevent the spread of infection to other residents. RN B stated hand washing with soap and water was required to get rid of the c. diff microbes and that hand sanitizer alone was not effective. RN B stated to use Sani Wipes to wipe surfaces. RN B stated if proper precautions were not taken, c. diff could be spread to other residents and could lead to an outbreak. The MA stated it could cause diarrhea, dehydration, and malnutrition which could lead to kidney issues, electrolyte imbalance, and possible death. Both the MA and RN B stated they did not remember when they were last in serviced on hand washing and that the last in-service on isolation precautions was possibly before Christmas. Observation on 06/25/24 at 2:17 PM of Resident #19's door revealed the ADON placed bleach wipes in the PPE holder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/25/24 at 2:27 PM, the TN stated the last in-service on hand washing and isolation precautions was recently. The TN stated she was not aware that Resident #19 had c. diff results pending. The TN stated the PPE for c. diff precautions was gown, gloves, and hand washing. The TN stated she would keep the supplies for a resident that was on c. diff precautions separate from supplies used for other residents. The TN stated she thought the alcohol/ ammonium wipes were effective against c. diff. After the TN read the label of the alcohol/ ammonium wipes she stated she did not think they would be effective against c. diff. The TN stated the Clorox wipes were effective against c. diff. The TN stated if hands or equipment were not cleaned properly, it could lead to the infection being spread to other residents which could cause them to become dehydrated, ill, or could possibly die. In an interview with the ADON and the DON on 06/25/24 at 2:47 PM, the ADON stated the last in service on hand washing and different types of isolation was in May, about a month ago. The ADON stated a resident should be put on c. diff precautions as soon as it was suspected and stay on them until after the c. diff test results are back. The ADON stated if the resident was positive for c. diff, then the precautions have to stay in place until a negative c. diff test was received. The ADON stated that Resident #19 possibly having c. diff was not discussed in the morning meeting and it did not come out on the 24-hour report because it was placed on there 19 minutes after the morning report was run. The ADON stated the nurse who entered the c. diff test should have asked the physician for an isolation order when she requested the test. Then ADON stated the difference between contact and c. diff isolation was that regular wipes could not be used for c. diff. The DON stated bleach wipes had to be used with c. diff precautions and that hand washing with soap and water was required to eliminate c. diff spores. Record review of CDC guidance 483.80(a)(1) on EBP: A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to S483.70(e) and following accepted national standards. Record review of the facility's Infection Prevention and Control Program Policy dated 05/13/23 stated in part: This facility has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following all policies and procedures related to the program. 5. Isolation Protocol (Transmission-Based Precautions): (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. 13. Resident/Family/Visitor Education and Screening: c. Isolation signs are used to alert staff, family members, and visitors of transmission-based precautions. 50039