| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675423 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ashford Gardens | 7210 Northline Dr<br>Houston, TX 77076 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644<br><br>Based on observation, interview, and record review the facility failed to immediately consult with the resident's physician when there was a change in residents health status for 1 of 8 residents (Resident #72) reviewed for notification of changes.<br><br>LVN A failed to notify Resident #72's physician when he reported to him that a car ran over his foot while out of the facility on an unknown date.<br><br>This failure could place residents at risk of injury, hospitalization , or death.<br><br>Findings include:<br><br>Record review of Resident #72's face sheet revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnosis included multiple sclerosis and seizures.<br><br>Record review of Resident #72's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. He required assistance from staff with ADL care.<br><br>Record review of Resident #72's care plan dated 3/3/23 - Current revealed the resident was at risk for injury related to falls and was resistant to care. Record review of Resident #72's care plan initiated 12/9/24 revealed no documentation of his allegation that a car ran over his foot.<br><br>Record review of Resident #72's nursing note dated 12/6/24 written by LVN O revealed resident complained of right foot pain due to a car running over his foot 2 days ago. No swelling noted, no warmth to touch, no bruising on right foot. Resident medicated for pain, NP notified, and new order received for right foot x ray stat.<br><br>Record review of Resident #72's Radiology report dated 12/6/24 revealed no fractures to right ankle, foot, or tibia and fibula.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 1/8/25 at 4:30 p.m., LVN A said Resident #72 returned to the facility from the store late at night and told him someone hit him. He said the resident informed him the ambulance brought him back to the facility and nothing was wrong with him. LVN A said he assessed the resident, and he was normal with no pain. He said he did not report the incident to anyone and did not document because nothing was wrong. He said if something was wrong, he would have notified the MD. LVN A said he left to go home and was off work for the next few days.<br><br>In an interview on 1/9/25 at 8:13 a.m., the DON said LVN A should have notified the MD, DON, and Administrator of what Resident #72 said. She said the resident could have been hurt and at risk for harm.<br><br>In an observation and interview on 1/9/25 at 11:52 a.m., of Resident #72, he shrugged his shoulder when asked if he had an incident where a car ran over his foot. He said he had normal pains.<br><br>In an observation on 1/9/25 at 12:49 p.m., the Social Worker conducted a BIMS assessment on Resident #72 with a result of 14 of 15 which indicated no cognitive impairment.<br><br>In an interview on 1/9/25 at 1:35 p.m., the Administrator said she was not aware Resident #72 said his foot was run over by a car until the Surveyors started investigating it. She said she would have requested a physical assessment, notified the doctor, reported it to State and investigated it.<br><br>In an interview on 1/9/25 at 2:29 p.m., the DON said she expected staff to notify her of any incident to know what is going on and keep the residents safe. She said LVN A informed her (upon investigation) that Resident #72 said someone hit or ran over him with a car. She said LVN A assessed the resident and there was no redness, swelling or signs of injury. She said LVN A did not report it to anyone. She said she would have notified the MD.<br><br>In an interview on 1/10/25 at 8:33 a.m., Resident #72's MD P said she was notified of Resident #72's incident from NP A on 12/6/24. She said NP A told her Resident #72 was hit by a car and his right foot and ankle were hurting. She said she ordered an x-ray. She said she would have liked to have been notified when the facility first became aware in order to know it occurred, what the findings were, and to determine the next steps. She said she would have recommended to monitor and be notified of any changes in swelling and pain and for the resident to be seen on the next visit.<br><br>In an interview on 1/10/25 at 8:50 a.m., LVN O said (on 12/6/24) Resident #72 asked her for pain medicine. She said he reported his foot was hurting. She assessed his foot and saw no swelling, redness, warmth, and no apparent injury. She said the NP reported to her approximately 10-15 minutes later that Resident #72 said a car ran over him. LVN O said she was not previously aware of that allegation. She said she reported it to the next nurse but did not report it to the DON or Administrator because she thought they knew since it happened a couple of days ago.<br><br>In an interview on 1/10/25 at 9:06 a.m., NP A said Resident #72, who was not her patient, reported to her (on 12/6/24) that his ankle was hurting, and he got hit by a car approximately 2 days ago. She said there was no apparent injury. She said she notified the MD, and ordered an x-ray on his ankle, foot, and tibia/fibula.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's Physician Notification policy updated March 2019 read in part, .The types of conditions which arise frequently are listed. This list is not inclusive .it is the responsibility of the nursing staff to observe the change, make an assessment, and notify the physician as indicated based on the assessment . The nurse will: recognize the condition change, monitor the patient, and continue to assess the condition and changes. Notify the physician, patient, and patient representative of any change in condition . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644<br><br>Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments for 2 of 8 residents (Resident #72 and #105) reviewed for care plans.<br><br>The facility failed to care plan Resident #105's gastrostomy status nor tube feeding.<br><br>The facility failed to care plan Resident #72s allegation that a car ran over his foot while out of the facility.<br><br>This failure could place residents at risk of not receiving individualized care and services.<br><br>Findings include:<br><br>1. Record review of Resident #105's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnosis of gastrostomy status (opening into the stomach from the abdominal wall.<br><br>Record review of Resident #105's Admission MDS assessment dated [DATE] revealed a BIMS score could not be conducted due to medical conditions. According to the MDS, the resident had diagnoses of dysphagia (trouble swallowing) and gastrostomy. The MDS revealed Resident #105 was on a feeding tube (nutrition through a tube) while a resident.<br><br>Record review of Resident #105's Care Plan from 10/8/24, did not mention the gastrostomy or tube feeding.<br><br>Record review of Resident #105's chart revealed the following orders from MD P:<br><br>- NPO diet, NPO texture, NPO consistency. Ordered on 11/26/24.<br><br>- Enteral (through the intestine)-Check Tube Placement, every shift. Check tube for proper placement by auscultation (listening) of injected air or visual inspection of aspirated (sucked out) stomach contents prior to instilling medication, and/or initiating a feeding. Ordered on 11/26/24.<br><br>- G Tube Site Care, every day shift. Check GT site daily for s/s of infection. Cleanse with Normal Saline or soap and water as appropriate. Apply dry dressing if drainage noted. Ordered on 11/26/24.<br><br>- Enteral Feed Order, every shift. Isosource 1.5 at 60 ml/hr via feeding tube for 22 hours, to run continuously until total volume of 1320 ml administered. May remove for care and services. 2 hour bowel rest every 24hr. Ordered on 12/23/24.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #105's chart revealed an H&P dated 12/12/24 from NP M, which revealed the resident received a gastrostomy tube and started on tube feedings before he was admitted to the facility on [DATE].<br><br>Record review of Resident #105's nurse's note dated 12/13/24 by LVN C, revealed the resident was on g-tube feedings and tolerated them.<br><br>In an observation on 1/7/25 at 9:38 a.m., Resident #105 was lying on his back in bed, with his g-tube running Isosource 1.5 at 60ml/hr.<br><br>In an interview with MDS K on 1/10/25 at 9:15 a.m., he said he was responsible for comprehensive care plans triggered by the MDS. He said the acute care plans were done by the unit managers, and there were 2-3 of them. He said the unit manager would put the care plan in and then he would check to make sure the care plan made sense and had goals and interventions entered correctly.<br><br>In an interview with the Clinical Resource Nurse on 1/10/25 at 12:52 p.m., she said the Unit Managers were responsible for the acute care plans.<br><br>In an interview with the DON on 1/10/25 at 12:54 p.m., she said the Infection Preventionist updated the care plan regarding anything to do with infection control or antibiotics. She said there was not anyone specific who updated the care plans and that everyone was doing it since they were merging over to the new EMR system. She said there were care plans in the old system and care plans in the new system. She said as the resident's quarterly review came up they were merging the care plans over to the new system and they had a year to use the old system. The DON said all of the leadership team was updating the care plans and there was not one specific person.<br><br>2. Record review of Resident #72's face sheet revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnosis included multiple sclerosis and seizures.<br><br>Record review of Resident #72's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. He required assistance from staff with ADL care.<br><br>Record review of Resident #72's care plan dated 3/3/23 - Current revealed the resident was at risk for injury related to falls and was resistant to care. He also rejected or resisted care (taking medications/injections ADL assistance or eating), refused air mattress, and wound treatments. Interventions were to talk to resident about reasons for refusal of care and potential risks and identify times/approaches/staff that result in least resistance. When care is refused, remind resident of potential risk. Coax but do not force compliance.<br><br>Record review of Resident #72's care plan initiated 12/9/24 revealed no documentation of his allegation that a car ran over his foot or any other behaviors.<br><br>Record review of Resident #72's nursing note dated 12/6/24 written by LVN O revealed the resident complained of right foot pain due to a car running over his foot 2 days ago. No swelling noted, no warmth to touch, no bruising on right foot. Resident medicated for pain, NP notified, and new order received for right foot x ray stat.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #72's Radiology report dated 12/6/24 revealed no fractures to right ankle, foot, or tibia and fibula.<br><br>In an interview on 1/8/25 at 4:30 p.m., LVN A said Resident #72 returned to the facility from the store late at night and told him someone hit him. He said the resident informed him the ambulance brought him back to the facility and nothing was wrong with him. LVN A said he assessed the resident, and he was normal with no pain. He said he did not report the incident to anyone and did not document because nothing was wrong. He said if something was wrong, he would have notified the MD. LVN A said he left to go home and was off work for the next few days.<br><br>In an observation and interview on 1/9/25 at 11:52 a.m., of Resident #72, he shrugged his shoulder when asked if he had an incident where a car ran over his foot. He said he had normal pains.<br><br>In an interview on 1/9/25 at 12:28 p.m., the Social Worker said she was unaware of the alleged incident with Resident #72. She said she would have care planned it, determined what happened, reviewed medications, and tried to prevent it from happening again.<br><br>In an observation on 1/9/25 at 12:49 p.m., the Social Worker conducted a BIMS assessment on Resident #72 with a result of 14 of 15 which indicated no cognitive impairment.<br><br>In an interview on 1/9/25 at 1:35 p.m., the Administrator said she was not aware Resident #72 said his foot was run over by a car until the Surveyors started investigating. She said the incident should have been care planned, staff in-serviced, and education provided to the resident. She said Resident #72 did go in and out the facility and she warned him before to be careful. She said he was not deemed incompetent and had the right to make the decision to go out.<br><br>In an interview on 1/9/25 at 2:29 p.m., the DON said she was not aware that Resident #72 said someone ran over him and did not see the nurses note until the Surveyor showed her. She said the facility recently switched electronic systems and the note was not originally there, once the resident readmitted on [DATE] it showed up. She said the incident should have been care planned so facility staff know what accusations were made when he was out of the building. She said even though he said he was run over; he was alert and oriented and the facility could not force him to stay but could continue to monitor for pain and talk to him about being careful.<br><br>In an interview on 1/10/25 at 8:50 a.m., LVN O said (on 12/6/24) Resident #72 asked her for pain medicine. She said he reported his foot was hurting. She assessed his foot and saw no swelling, redness, warmth, and no apparent injury. She said the NP reported to her approximately 10-15 minutes later that Resident #72 said a car ran over him. LVN O said she was not previously aware of that allegation. She said she reported it to the next nurse but did not report it to the DON or Administrator because she thought they knew since it happened a couple of days ago.<br><br>In an interview on 1/10/25 at 9:06 a.m., NP A said Resident #72, who was not her patient, reported to her (on 12/6/24) that his ankle was hurting, and he got hit by a car approximately 2 days ago. She said there was no apparent injury. She said she notified the MD, and ordered an x-ray on his ankle, foot, and tibia/fibula.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 1/10/25 at 9:15 a.m., MDS K said he was unaware of the incident where Resident #72 alleged his foot was ran over by a car. He said one of the Unit Managers would have updated the care plan. He said the incident was not discussed in morning meeting. He said if aware, he would have made sure psych services were implemented to ensure his mind was right and reviewed his medications.<br><br>In an interview on 1/10/25 at 9:30 a.m., Unit Manager T said the MDS K and MDS R primarily updated care plans, but she was able to do them if asked. She said LVN W did staffing and oversaw falls and incidents on the care plans. She said if facility staff asked her to do a care plan she would because she was a nurse, but she did not really have anything to do with them. She said she was just notified of the incident with Resident #72 today and no one said anything to her about his foot being ran over. She said she did not recall discussing the incident in morning meeting. She said she would have put something in place, monitored him for pain, determine what happened, and educate him on safety.<br><br>In an interview on 1/10/25 at 12:20 p.m., the Administrator said MDS K and MDS R updated the care plans.<br><br>Record review of the facility's Care Plans, Comprehensive Person-Centered policy dated March 2022 read in part, .a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Policy Interpretation and Implementation . 1.The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment and no more than 21 days after admission . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644<br><br>Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (Resident #92) reviewed for accident hazards.<br><br>The facility failed to ensure Resident #92 was supervised while smoking outside on the back patio on 1/8/25.<br><br>These failures could place residents at risk for injuries.<br><br>Findings included:<br><br>Record review of Resident #92's face sheet dated 1/8/25 indicated a [AGE] year-old male readmitted on [DATE]. His diagnoses included diabetes mellitus, hypertension, disease of stomach and duodenum, schizophrenia, and peripheral vascular disease.<br><br>Record review of Resident #92's annual MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15 which indicated moderate cognitive impairment. He required assistance from staff with ADL care.<br><br>Record review of Resident #92's care plan dated 12/10/24 and revised on 1/8/25 revealed he was at risk for injury related to not complying with facility protocol for resident's smoking. Interventions were to educate the resident on the facility's tobacco/smoking policy and orient resident to smoking times and procedures.<br><br>Record review of Resident #92's Smoking and Safety Evaluation dated 12/10/24 revealed he used tobacco products and followed the facility's policy on location and time of smoking.<br><br>In an interview on 1/7/25 at 3:54 p.m., Resident # 92 said he was not a child and should be able to smoke on his own. He said facility staff removed smoking paraphernalia from him earlier today. He said he went out to smoke on his own sometimes.<br><br>In an observation and interview on 1/8/25 at 3:16 p.m., of Resident #92 outside on the back patio. He pulled a cigarette and lighter out and began to smoke by himself. Approximately 4 minutes later at 3:20 p.m. CNA N escorted residents out to the back patio to smoke. Resident #92 was outside smoking in a non-smoking area. Resident #92 said he been outside for around 30 minutes and just started smoking 2-3 minutes prior to the staff coming outside. He said he borrowed a cigarette from a [NAME] and had his lighter on him in his bag. CNA N said this was her first time bringing the residents out to smoke and referred to a list of names, where Resident #92 was not listed. She said she did not notice if Resident #92 was smoking and did not provide a cigarette to him.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 1/10/25 at 4:07 p.m., the Administrator said she set out smoking times and hours for residents to smoke and provided a staff member to ensure safe smoking. She said no resident could smoke unsupervised. She said she has had problems with Resident #92 before regarding smoking and had taken 3 packs of cigarettes from him. She said there was no risk to Resident #92 smoking unsupervised because he was a safe smoker. She said there was a fire extinguisher available in the designated smoking area on the back wall and not the side of the building.<br><br>Record review of the facility's smoking policy dated 1/4/24 read in part, .Policy: to maintain safety for residents who smoke . Procedure: 1. The center will designate a smoking area where smoking will be permitted. Smoking will be prohibited in any area other than the designated smoking area . 8. Residents are not permitted to retain in their possession any smoking paraphernalia like cigarettes, lighters, matches, tobacco, tobacco vaporizer products, etc. All smoking paraphernalia will be stored in the medication room . 12. When a resident smokes, it will be under the direct supervision of the staff. Direct supervision must be provided throughout the entire smoking period . |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644<br><br>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 6% based on 2 errors out of 29 opportunities which involved 2 of 8 residents (Resident #47 and #105) and 2 of 8 staff (MA D and LVN R) reviewed for medication administration.<br><br>MA D handed Resident #47 (who did not self-administer) his eye drops, and the resident administered the wrong dose per physician orders on 1/8/25. MA D did not provide Resident #47 with instructions.<br><br>LVN R crushed and administered Lansoprazole DR ODT (a delayed release medication used to treat heartburn and certain other conditions caused by too much acid in the stomach) to Resident #105 via PEG tube on 1/8/25. Delayed Release formulations should not be crushed.<br><br>These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health.<br><br>Findings included:<br><br>1. In an observation on 1/8/25 at 8:08 a.m., MA D prepared Resident #47's medication for administration. MA D handed ultra lubricant eye drops to Resident #47 and did not give directions. Resident #47 inserted one drop in each eye.<br><br>Record review of Resident #47's face sheet dated 1/10/25 revealed a [AGE] year-old male who readmitted on [DATE]. His diagnosis included unspecified disorder of eye and adnexa (accessory or adjoining anatomical parts,), cerebral infarction (stroke), hypertension (high blood pressure), and bladder disorder.<br><br>Record review of Resident #47's annual MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. He was independent with ADL care and needed setup or clean-up assistance with eating, oral hygiene, and shower/bathing.<br><br>Record review of Resident #47's care plan dated 1/8/25 revealed the resident requested to self-administer his own eye drops and nasal spray. Interventions were to hold the medication and the cart and hand to the resident at the time of administration. Resident will have a good understanding of and return demonstration of how the medication is to be self-administered.<br><br>Record review of Resident #47's Physician orders for January 2025 revealed an order for:<br><br>Refresh Tears eye drops, instill 2 drops in both eyes three times a day for dry eye, order date 11/3/24.<br><br>There were no orders for self-administration.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #47's Late Entry Nursing note- Self Administration of Medication effective 12/21/24 (created 1/8/25 at 10:26 a.m. by the Clinical Resource Nurse) revealed he was able to administer refresh eye drops.<br><br>In an interview on 1/8/25 at 8:14 a.m., MA D said Resident #47 was supposed to apply two drops in each eye but only applied one in the left eye and two in the right eye. He said he did not give the resident directions for the eye drops because he was nervous. He said the resident refused for staff to administer his eye drops and he reported it to the nurses. He said the nurse said they would reach out to the MD but that had not happened yet.<br><br>In interview on 1/10/25 at 1:23 p.m., the DON said nursing staff have to give directions to the resident. She said staff should not just give residents' their medication and expect them to know what to do.'<br><br>In an interview on 1/10/25 at 3:00 p.m., the Clinical Resource Nurse said the self-administration of medication assessment for Resident #47 was completed on 1/8/25.<br><br>2. In an observation on 1/8/25 at 8:17 a.m., LVN R prepared Resident #47's medication for administration via g-tube. She retrieved Lansoprazole from the medication cart. The pharmacy label read Lansoprazole ODT 30 mg but the foil pouch read Lansoprazole DR ODT 30 mg. LVN R crushed the Lansoprazole DR and administered it along with the other medications to Resident #105 via g-tube.<br><br>Record review of Resident #105's face sheet dated 1/10/25 revealed a [AGE] year-old male who admitted on [DATE]. His diagnosis included respiratory failure, gastrostomy status (presence of a surgical opening into the stomach), disease of stomach and duodenum, and chronic obstructive pulmonary disease.<br><br>Record review of Resident #105's admission MDS assessment dated [DATE] revealed his cognitive skills for daily decision making were severely impaired. He required assistance from staff with ADL care.<br><br>Record review of Resident #105's Physician orders for January 2025 revealed orders for:<br><br>Lansoprazole 30 mg ODT give 1 tablet via g-tube related to disease of stomach and duodenum, order date 10/22/24,<br><br>May crush medications or open capsules unless contraindicated, order date 11/1/2024.<br><br>In an interview on 1/8/25 at 8:30 a.m.,,. LVN R said when preparing medication, she was trained to look at the label three times and verify the orders and patient. She said saw that the foil pouch read Lansoprazole DR ODT but she did not connect the dots between delayed release and not crushing. She said you could not crush enteric coated, extended or delayed release medications because the medication was intended to last longer and if crushed, there would be no lasting effect. She said there could be a risk of the resident not receiving the desired effect if crushed. She said she was not sure about the Lansoprazole DR ODT and would verify with the MD and pharmacy.<br><br>In an interview on 1/8/25 at 8:40 a.m., LVN R said she called the pharmacy, and they said the Lansoprazole could be crushed.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 1/10/25 at 1:28 p.m., the DON said the facility had a do not crush list which included enteric coated and some delayed release medications. She said if staff were unsure of which medications to crush or not crush, they could call the pharmacy.<br><br>In an interview on 1/10/25 at 4:13 p.m., the Administrator said staff should review the MD orders during medication administration. She said residents had to be instructed by the MA on what to do every time they administered the medication.<br><br>Record review of document Oral Dosage Forms That Should Not Be Crushed 2016 provided by the facility revealed Prevacid Solutab (Lansoprazole) tablet was listed. Note: orally disintegrating do not swallow; dissolve in water only and dispense via dosing syringe of NG tube.<br><br>Record review of the Prescribing information for Prevacid SoluTab (lansoprazole) Delayed-Release orally disintegrating tablet from the www.accessdata.fda.gov dated 9/2012 revealed Lansoprazole Solutab should not be broken or cut. For administration via a nasogastric tube, place a tablet in a syringe and draw up water, shake gently to allow for quick dispersal.<br><br>Record review of the facility's undated Medication Administration policy read in part, .2. The 6 rights of medication administration a. right patient . b. Right drug . c. Right dose . d. Right dosage form . e. Right time . F. Right route . g. Right indication . 7. Eye medication administration . c. Resident may not administer their own eye drops unless self-administration assessment/order/care plan is filed . 9. Enteral tube medication administration . b. dilute liquids and crush and dilute tablets according to facility policy . |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644<br><br>Based on observation, interview, and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete for 1 of 8 residents (Resident #72) reviewed for medical records.<br><br>LVN A failed to document in Resident #72's medical record the allegation made that a car ran over his foot while out of the facility and the assessment he conducted on the resident on an unknown date.<br><br>This failure could place residents at risk of injury, hospitalization , or death.<br><br>Findings include:<br><br>Record review of Resident #72's face sheet revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnosis included multiple sclerosis and seizures.<br><br>Record review of Resident #72's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. He required assistance from staff with ADL care.<br><br>Record review of Resident #72's care plan dated 3/3/23 - Current revealed the resident was at risk for injury related to falls and was resistant to care. Record review of Resident #72's care plan initiated 12/9/24 revealed no documentation of his allegation that a car ran over his foot.<br><br>In an interview on 1/8/25 at 4:30 p.m., LVN A said Resident #72 returned to the facility from the store late at night and told him someone hit him. He said the resident informed him the ambulance brought him back to the facility and nothing was wrong with him. LVN A said he assessed the resident, and he was normal with no pain. He said he did not report the incident to anyone and did not document because nothing was wrong. He said if something was wrong, he would have notified the MD. LVN A said he left to go home and was off work for the next few days.<br><br>In an interview on 1/9/25 at 8:13 a.m., the DON said LVN A should have notified the MD, DON, and Administrator of what Resident #72 said. She said the resident could have been hurt and at risk for harm.<br><br>In an interview on 1/9/25 at 10:46 a.m., LVN A said the facility recently switched electronic systems and he did not remember documenting anything. He said he did not document because nothing was wrong and the resident said things all the time.<br><br>In an observation and interview on 1/9/25 at 11:52 a.m., of Resident #72, he shrugged his shoulder when asked if he had an incident where a car ran over his foot. He said he had normal pains.<br><br>In an observation on 1/9/25 at 12:49 p.m., the Social Worker conducted a BIMS assessment on Resident #72 with a result of 14 of 15 which indicated no cognitive impairment.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 1/9/25 at 1:35 p.m., the Administrator said she was not aware Resident #72 said his foot was run over by a car until the Surveyors started investigating it.<br><br>In an interview on 1/9/25 at 2:29 p.m., the DON said she expected staff to notify her of any incident to know what is going on and keep the residents safe. She said LVN A informed her (upon investigation) that Resident #72 said someone hit or ran over him with a car. She said LVN A assessed the resident and there was no redness, swelling or signs of injury. She said LVN A did not report it to anyone. She said the initial assessment (by LVN A) should have been documented.<br><br>Record review of the facility's Charting and Documentation policy dated July 2017 read in part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy: . 2. The following information is to be documented in the resident medical record: . e. events, incidents or accidents involving the resident .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722<br><br>Based on observations, interviews, 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 1 of 1 facility and 2 of 16 residents (Resident #217 and Resident #218) reviewed for infection control.<br><br>1. The facility failed to establish and provide documentation for a water management program as part of the infection control program.<br><br>2. The facility failed to ensure Housekeeper L wore the appropriate PPE for contact precautions when she was cleaning the room for Resident #217.<br><br>3. The facility failed to ensure LVN S wore appropriate PPE when administering IV medication to Resident #218 on 1/8/25 who was on enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes).<br><br>This failure could place residents at risk of exposure to Legionnaires' disease (a serious type of lung infection caused by Legionella bacteria which can live in standing water within facility water systems), and other infectious diseases due to improper infection control practices.<br><br>Findings include:<br><br>1. In an interview on 1/9/25 at 2:15 p.m., Maintenance V said he had worked at the facility for 18yrs. He said he did not have a policy or protocol for checking for water-borne pathogens. He said he checked the backflow from the city water, with the Fire Marshall once a year. He said he also checked the water heater temperatures once a day, but he did not know anything about a Water Management Program or about Legionella.<br><br>In an interview on 1/9/25 at 2:17 p.m., the ADON, who was the Infection Preventionist, said they had never had any residents who had Legionnaire's Disease.<br><br>In an interview on 1/9/25 at 2:18 p.m., the Clinical Resource Nurse, said there was a policy on water-borne illness, and she would call Maintenance V's boss and ask him about it.<br><br>In an interview on 1/10/25 at 12:24 p.m., the ADON/Infection Preventionist said she had been with the facility since August 2024. She said she did not know anything about a policy/procedure on water-borne illness or water management. She said that would be maintenance's department.<br><br>In an interview on 1/10/25 at 12:54 p.m., the DON said that she had heard of legionella bacteria, but she did not know anything about a policy or procedure on Water Management. She said she would check with the Administrator.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In an interview on 1/10/25 at 4:14 p.m., the Administrator, said she did not know there was supposed to be a Water Management System. She said she thought she had heard about it a few years ago but was not for sure. She said she would get it fixed right away.<br><br>2. Record review Resident #217's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses of urinary tract infection, respiratory failure (not enough oxygen in the blood), severe sepsis with shock (severe infection throughout the body that is starting to shut down organs), type 2 diabetes (body does not produce insulin or resists it), aphasia (trouble speaking), dysphagia (trouble swallowing), COPD (chronic lung disease that reduces airflow and makes breathing difficult), tracheostomy (opening in the neck to provide an airway to the lungs), gastrostomy (opening into the stomach from the abdominal wall), and pressure ulcer of the sacrum (tailbone).<br><br>Record review of Resident #217's Admission MDS assessment dated [DATE] revealed a BIMS could not be conducted due to medical conditions. The MDS revealed she was dependent (the helper does all of the effort or the assistance of 2 or more helpers is required) with all ADLs. The MDS indicated the resident had an indwelling catheter (tube into the bladder to drain urine) and was always incontinent of bowel. Resident #217 was on a feeding tube (nutrition through a tube into the stomach) and had an unstageable (not stageable due to coverage of wound bed by dead skin or infection) pressure ulcer.<br><br>Record review of Resident #217's care plan dated 12/10/24 revealed a Focus: Resident is at risk for infection related to Candida Auris (resistant fungal infection), tracheostomy, and g tube and she needed to be on Enhanced Barrier Precautions (Initiated: 12/11/24, Revised: 12/11/24). Interventions: Educate resident/RP on infection control practices. Focus: Resident requires tube feeding (Initiated: 12/10/24, Revised: 12/10/24). Interventions: Provide local care to G-tube site as ordered. Focus: Resident has Stage 4 pressure ulcer to sacrum (Initiated: 12/26/24, Revised: 12/26/24). Interventions: Administer treatments as ordered. Focus: Resident has a tracheostomy (Initiated: 12/10/24, Revised: 10/10/24). Interventions: Oxygen via trach collar at 5L continuously.<br><br>Record review of Resident #217's Physician Orders revealed the following order from MD P:<br><br>- Contact Isolation, every shift. Follow facility policy-Use contact precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Ordered on 1/7/25.<br><br>In an observation of Resident #217 on 1/7/25 at 10:44 a.m., there was a contact isolation sign on her door with PPE outside the room. The resident was lying on her left side with her eyes closed. She had a tracheostomy with 10L of oxygen, a foley catheter, and a gastrostomy tube.<br><br>In an observation of Resident #217 on 1/8/25 at 9:39 a.m., her door was open, and Housekeeper L was in her room cleaning without any PPE on. There was still a contact isolation sign on Resident #217's door.<br><br>In an interview with the Housekeeping Supervisor on 1/8/25 at 9:41am, she said when there was a contact isolation sign on the door, everyone including housekeeping had to wear a gown and gloves into the room. She said Housekeeper L was new and had just started the day before and did not know.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In an interview using Spanish translator services with Housekeeper L on 1/8/25 at 9:45am, she said she thought she only wore a gown if she was going to touch the resident. She said she started at the facility in November 2024 and her trainer did not wear a gown into any of the rooms. She said she could not read the isolation sign because it was in English, and she could not read English. She said she did not know any of the signs said she had to wear a gown. Once the surveyor explained cross contamination Housekeeper L voiced understanding and the importance of wearing a gown.<br><br>3. Record review of Resident #218's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses of infection and inflammatory reaction due to internal left knee prosthesis, enterococcus (a large group of lactic acid bacteria), type 2 diabetes (body does not make insulin or resists it), anemia (not enough iron), and pressure ulcer of unspecified site.<br><br>Record review of Resident #218's Admission MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated normal cognition. The MDS revealed she had recent knee replacement surgery. She had an unstageable pressure injury presenting as a deep tissue injury, surgical wound, and was receiving IV medication.<br><br>Record review of Resident #218's care plan dated 1/3/25, did not have the IV antibiotics, the surgical wound, or the isolation precautions on it.<br><br>Record review of Resident #218's hospital records from 1/1/25 revealed she had a revision of her left total knee replacement and now had a surgical site infection with Enterococcus Faecalis (type of bacteria), which would require several weeks of IV antibiotics.<br><br>Record review of Resident #218's chart revealed a nursing note from 1/2/25 that revealed the resident admitted with a diagnosis of infected left knee due to arthroplasty, she had a left knee incision and a PICC (flexible tube that's inserted into a vein in the arm and threaded into a large vein near the heart) to her RUE line for IV antibiotics.<br><br>Record review of Resident #218's Physician Orders revealed the following orders from MD P:<br><br>- Ampicillin Sodium Injection Solution 2 GM (type of antibiotic), 2 grams intravenously every 8 hours related to direct infection of left knee in infectious and parasitic diseases. Ordered on 1/3/25.<br><br>- Ceftriaxone Sodium Injection Solution 2 GM (type of antibiotic), 2 grams intravenously every 12 hours related to direct infection of left knee in infectious and parasitic diseases. Ordered on 1/3/25.<br><br>- IV-Flush SASH Method, every shift related to infection and inflammatory reaction due to internal left knee prosthesis. Ordered on 1/4/25.<br><br>- Wound Treatment-Dry Dressing, every day shift, every Mon, Wed, Fri. Cleanse SDTI to Lt heel with Normal Saline or Skin Cleanser, Pat dry, apply skin prep and cover with dry dressing. Ordered on 1/6/25.<br><br>- Wound Treatment-Dry Dressing, every day shift, every Mon, Wed, Fri. Monitor surgical dressing to LLE. DO not remove dressing wrap with kerlex and ace wrap, notify MD of any changes. Ordered on 1/6/25.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In an interview and observation of Resident #218 on 1/7/24 at 10:35 a.m., the resident was sitting in a recliner in her room with a brace on her left leg. There was not an isolation sign on her door. A PICC line was seen on her RUA. She said she was there for an infection of her left knee and was on IV antibiotics.<br><br>In an observation and interview on 1/8/25 at 9:06 a.m., LVN S administered Resident #218's Ampicillin IV via her PICC line. She wore gloves but did not wear a gown. She said enhanced barrier precautions was used for residents with an artificial opening such as a PEG tube and PICC line. She said she wore gloves but did not wear a gown. She said she had training on EBP but there was no PPE cart present in the resident's room.<br><br>In an interview and observation of Resident #218 on 1/8/25 at 9:35 a.m., staff were putting an Enhanced Barrier Precaution sign on her door and PPE outside of her room. The resident said the facility had just added the sign to the door and they had not been wearing any PPE before.<br><br>In an interview with the ADON/Infection Preventionist on 1/10/25 at 12:24 p.m., she said Enhanced Barrier Precautions was for any resident with artificial openings, PICC lines, catheters, or g-tubes. She said staff were expected to wear gloves and gowns with ADL care, transfers, when giving g-tube meds or IV meds, and whenever providing up close and personal care, including therapists. She said when a resident was on contact isolation, everyone needed to wear gloves, gowns, and a face shield if coming in contact with something that might splash. She said that included family, doctors, housekeeping, everyone. The Infection Preventionist said contact isolation was for residents that had MDROs like ESBL of the urine or any kind of bugs in wounds. She said if a staff member did not wear PPE into a contact isolation room, the staff member could get an infection and could transfer it to another resident. She said if staff did not wear PPE in an EBP room they could spread infections to other residents. She said she provided training on infection control and had an in-service this week and in December.<br><br>In an interview with the DON on 1/10/25 at 12:54 p.m., she said she expected staff to stop and look at the isolation signs before going in and touching the patient, so they knew how to suit up. She said if someone did not wear PPE and went into a EBP room they could spread infection to and from the resident. She said if someone went into a contact isolation room without PPE, they could get an infection. The DON said for contact isolation everyone had to wear PPE, including housekeeping.<br><br>Record review of the facility's policy and procedure on Infection Control (revised November 2017) read in part: The facility must establish an infection prevention and control program (IPCP) that must include: A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases .An individual Infection Control Surveillance Report designed to identify possible communicable diseases or infections before they can spread to other persons in the facility must be completed by the nurse manager or designee upon the occurrence of any infection and reported to the Director of Nursing Services .<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Record review of the facility's policy and procedure on Legionella Surveillance and Detection (Revised September 2022) read in part: Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease is included as part of our infection surveillance activities. Legionella can grow in parts of building water systems that are continually wet .and certain devices can spread contaminated water droplets via aerosolization. Legionellosis outbreaks are generally linked to locations where water is held or accumulates and pathogens can reproduce .As part of the infection prevention and control program, all cases of pneumonia that are diagnosed in residents> 48 hours after admission are investigated for possible Legionnaire's diseases .If pneumonia or Legionnaire's disease is suspected, the nurse will notify the physician or practitioner immediately. Residents who have signs and symptoms of pneumonia may be placed on transmission-based (droplet) precautions .Diagnosis of Legionnaire's disease is based on a culture of lower respiratory secretions and urinary antigen testing .If Legionella is detected in one or more residents, the infection preventionist will: initiate active surveillance for Legionnaire's disease, notify the water management team, notify the local health department, and notify the administrator and the director of nursing services. |