STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675539	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bradford at Brookside	301 West Park Drive Livingston, TX 77351

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview, and record review, the facility failed to ensure that a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 20 residents reviewed for range of motion. (Resident #66) The facility did not ensure Resident #66's palm guard (device used as a barrier between fingers and palmar skin to prevent injury to the palm from severe finger flexion contracture) was placed in her hands bilaterally, after therapy assessed the resident's needs and referred the resident to restorative care. This failure could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of physician orders dated July 2024 indicated Resident #66, admitted [DATE], was a [AGE] year-old female with diagnoses of diabetes and benign neoplasm of the cranial nerve (a rare type of cancer that grows on the cranial nerves in the head or neck region causing weakness or loss of function in the affected area). Record review of the admission MDS assessment dated [DATE] indicated Resident #66 had severe cognitive impairment, had functional limitation in range of motion to both sides of the upper and lower extremities and was totally dependent for upper and lower body dressing and personal hygiene. Record review of a care plan dated 05/28/24 indicated Resident #66 received restorative care for passive ROM and splint/brace assistance. The goal was for the resident to achieve the highest level of optimal functioning. The intervention was to evaluate progress every month and PRN. During the following observations Resident #66's fingers on her bilateral hands were contracted inward towards the palm of each hand. The resident did not have a palm guard to her right hand and/or her left hand: *on 07/22/24 at 9:32 a.m., (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*on 0722/24 at 01:29 p.m., and *on 07/23/24 at 9:09 a.m. During observation and interview on 07/23/24 at 9:09 a.m., Resident #66 had a palm guard around the left wrist; not in the contracted left hand, and there was no palm guard to hand. LVN C said the resident was supposed to have the palm guard in her left hand. She said the resident had never had a palm guard for the right contracted hand since admission. The LVN reapplied the palm guard in the left hand. The right hand remained without a palm guard. She said she tried to put the palm guard back on the left hand when she noticed that it was off. She said Resident #66 did have contractures in both hands and did need the palm guards in both hands to prevent further contractures, but she had never seen a palm guard for the right hand. She said the Restorative Aide was the person responsible for placing the palm guards in the resident's hands. She said the possible negative outcome would be the resident's hands would become more contracted. During an interview on 07/23/24 at 1:23 p.m., Family Member D said Resident #66 was their family member and they did not remember ever seeing the palm guards in Resident #66's bilateral hands. During an interview on 07/23/24 at 03:16 p.m., the Director of Rehabilitation said Resident #66 was assessed for hand rolls, positioning and a wheelchair. He said the resident was seen by OT from 05/24/24 to 06/13/24 and was then referred to restorative. He said both of the resident's hands were contracted but the resident's right hand was tightly contracted, and they attempted to perform exercises on it, but the resident could not tolerate it. He said Resident #66 was referred to restorative for bilateral palm guards and range of motion exercise. He said the Restorative Aide was supposed to be placing palm guards in the resident's hands bilaterally daily. During observation, interview and record review on 07/24/24 at 8:01 a.m., Resident #66 was lying in bed with a palm guard to the left hand; there was no palm guard to the right hand. The Restorative Aide said she was seeing Resident #66 three times a week for ROM exercises. She said she was responsible for ensuring the resident had the palm guard in her left hand. She said she had too many residents to see and got pulled to the floor at times to work as a CNA and did not see the resident daily to ensure the palm guard was in her left hand. She said she only placed the palm guard in the resident's left hand, and she did not have a palm guard for the resident's right hand and had not been placing one in the right hand. She said the resident needed the palm guards in both hands. The Restorative Aide provided the surveyor with the Nursing Restorative Care Program document for Resident #66. The document indicated the restorative Plan of Care for Resident #66 was: . Patient will tolerate PROM exercises to BUE, as tolerated, within ROM tolerance, no s/sx of pain, 3 to 4 times a week. Patient will tolerate palmar guards on bilateral hands times 8 hours with no s/sx of redness, irritation, discomfort or pain, daily. The Restorative Aide said she was supposed to follow the plan of care but had not. She said she did not receive a palm guard for the resident's right hand and had not placed one in the right hand. She said she had not followed the restorative plan of care by not placing the palm guard in the resident's hands bilaterally and by not ensuring the palm guards were placed in the resident's left hand consistently every day. The Restorative Aide opened Resident #66's left and right hands for observation without open areas or odor noted. She said the possible negative outcome of not placing the palm guards in the resident's hands could be the resident's hands could become more contracted or she could get cuts in her hands from her fingernails. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/24/24 at 08:10 a.m. CNA E said the Restorative Aide was responsible for ensuring Resident #66 had the palm guards in her hands bilaterally. She said no one had told her she was responsible for ensuring the palm guards were in the resident's hands daily. She said she had only seen the palm guard in the resident's left hand and had not seen one in the right hand. During an interview on 07/24/24 at 8:15 a.m., the interim DON said his expectations were for Resident #66 to have the palm guards in place as specified in the restorative plan of care. He said not placing the palm guards in the resident's hand could lead to worsening of the resident's contractures. During observations on 07/24/24 at 10:23 a.m., after surveyor intervention, Resident #66 had palm guards in her hands bilaterally. The resident did not exhibit s/sx of pain. Record review of a Resident Mobility and Range of Motion policy revised July 2017 indicated: Policy Statement: 1. Residents will not experience an unavoidable reduction in range of motion. 2. Resident with limited range of motion will receive treatment and services to increase and/or prevent decrease in ROM.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview, and record review, the facility failed to ensure residents who entered the facility with an indwelling catheter were assessed for removal of the catheter as soon as possible and restore continence to the extent possible for 1 of 2 residents reviewed for urinary catheters. (Resident #275) The facility failed to attempt bladder retraining and discontinuation of an indwelling urinary catheter (a tube which is inserted into the bladder, through the urethra and remains in place to drain urine) for Resident #275 whose clinical condition did not necessitate catheterization. This failure could place residents with a urinary catheter at increased risk of dependence on a urinary catheter and urinary tract infections. Findings included: Record review of physician orders dated July 2024 indicated Resident #275, admitted [DATE], was a [AGE] year-old female with diagnoses of respiratory failure (a serious condition that makes it hard to breathe on your own) and anoxic brain damage (a potentially fatal brain injury that occurs when the brain is completely deprived of oxygen) The resident had an indwelling urinary catheter (a catheter which is inserted into the bladder to drain urine). Record review of a care plan dated 07/10/24 indicated Resident #275 had an indwelling urinary catheter and was at risk for urinary tract infection (UTI). Record review of the admission MDS assessment dated [DATE] indicated Resident #275 was unable to respond, had severe cognitive impairment, was dependent for all ADLs, had an indwelling urinary catheter, and had no active genitourinary (refers to the urinary and genital organs) diagnosis. During an observation and interview on 07/22/24 at 10:12 a.m., Resident #275 was lying in bed and was unable to respond to questions. The resident had a urinary catheter bag hung at bedside to gravity drainage (below the level of the bladder). Her family was at bedside and said she got the catheter during her hospitalization , but she was not sure why the resident needed a catheter. During an interview on 07/24/24 at 09:50 a.m., the Unit Manager said Resident #275 had no genitourinary diagnosis that necessitated the use of a catheter. She said she had called Resident #275's physician (after surveyor intervention) and obtained an order to begin bladder retraining (clamping the catheter tubing for two hours to stop the flow of urine and then unclamping the tubing to empty the bladder repeatedly to mimic urination) so her catheter could be discontinued. She said the facility had not attempted bladder retraining until the order was obtained today. She said residents who have catheters had an increased risk for UTIs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/24/24 at 10:05 a.m., the interim DON said an order had been obtained from Resident #275's physician to start bladder retraining so her catheter could be discontinued. He said Resident #275 did not have a related diagnosis necessitating a catheter and the physician should have been contacted earlier. He said his expectation was that all residents who were admitted to the facility with a catheter would have a diagnosis necessitating catheterization. He said possible negative outcome of providing catheters to residents who did not need them was the resident becoming reliant on a catheter to urinate. During an interview on 07/24/24 at 10:15 a.m., the Administrator said the facility should try bladder retraining and discontinuation of the catheter for all residents who were admitted with a catheter unless they had a medical diagnosis that indicated the use of a catheter. During an interview on 07/24/24 at 10:25 a.m., the Corporate Nurse said the facility did not have a policy to address diagnosis that indicated the use of a urinary catheter. She said facility policies only addressed skills and procedures such as catheter insertion and care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 20 residents reviewed for respiratory care and services. (Resident #66) *The facility failed to administer the correct dose of oxygen to Resident #66. This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included: Record review of physician orders dated July 2024 indicated Resident #66, admitted [DATE], was a [AGE] year old female with diagnoses of chronic respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues of your blood or when there is too much carbon dioxide in the blood) and a tracheostomy (a surgical opening into the windpipe to allow air to fill the lungs). The resident was to receive oxygen at 2-4 L/min via nasal cannula. Record review of the admission MDS assessment dated [DATE] indicated Resident #66 had severe cognitive impairment, received tracheostomy care, and received oxygen therapy. Record review of a care plan dated 06/20/24 indicated Resident #66 was unable to maintain oxygen saturation and received oxygen at 2-4 L/min via nasal cannula. During the following observations Resident #66 had oxygen in progress at 4.5 L/min via nasal cannula: *on 07/22/24 at 9:32 a.m., *on 0722/24 at 2:25 p.m., *on 07/23/24 at 8:50 a.m., and *on 07/23/24 at 8:57 a.m. During observation and interview on 07/23/24 at 8:57 a.m., LVN C said Resident #66's oxygen was set at 4. 5 L/min and should be set between 2 to 4 L/min nasal cannula. She said she had to suction the resident that morning and checked the resident's oxygen saturation levels (measurement of how much oxygen is bound to the hemoglobin in the red blood cells) and it was 98% (WNL) at that time but she did not check the setting of the oxygen dosage. She said it was her responsibility to assess each resident at the beginning of the shift and make sure their oxygen was set correctly. She said she would reset Resident #66's oxygen to 4L/min as ordered. She said the possible negative outcome of having the oxygen set too high would be the resident could become dependent on the higher dose of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/23/24 at 2:33 p.m., the interim DON said his expectations were for the staff to follow the orders for oxygen administration. He said the plan of care was not followed. He said Resident #66 could have received too much oxygen and she could become more dependent on the higher dose. Record review of the Oxygen Administration policy revised October 2010 indicated: Purpose- The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs to each resident for 1 of 7 residents reviewed for medications. (Resident #175) The facility failed to ensure Resident #175 was not administered a saline IV flush before administration of an IV antibiotic and an IV saline and an IV heparin flush after medication administration (SASH-saline administer, saline heparin) without a physician's order. This deficient practice could place residents at risk of consuming unprescribed medications, harm, and hospitalization . Findings included: Record review of Resident #175's face sheet indicated she was a [AGE] year-old-female admitted [DATE] with a diagnosis of UTI. She was to receive Piperacillin/Tazobactam (a penicillin antibiotic used to treat bacterial infections) 3.375 gm/NS 200 ml at 200 ml per hour via midline IV catheter. Record review of Resident #175's baseline care plan dated 07/16/24 indicated she was to receive IV antibiotics. Record review of Resident #175's Admission MDS dated [DATE] was incomplete at this time due to required time frame of completion. During record review of Resident #175's physician orders and reconciliation indicated Resident #175 was ordered Piperacillin/Tazobactam 3.375 gm/NS 200 ml at 200 ml per hour every 8 hours for 7 days with a start date of 7/16/24. The electronic medical record gave no indication of physician orders for NS 0.9% before antibiotic administration and NS 0.9% and 10 ml or Heparin 500 units/5 ml (100 USP units/ml) after administration of the antibiotic. Record review of Resident #175's MAR indicated she received Piperacillin-Tazobactam 3.375 gm IV every 8 hours for 7 days with a start date of 07/16/24 with no indication of the SASH IV flush. During an observation during the medication pass on 07/22/24 at 12:36 p.m., LVN A prepared and administered Piperacillin/Tazobactam 3.375 gm/NS 200 ml at 200 ml per hour to Resident #175. Prior to administration, LVN A flushed Resident #175's midline catheter with NS 0.9% 10 ml. After completion of the infusion, LVN A flushed Resident #175's midline catheter with NS 0.9% 10 ml followed by Heparin 500 units/5 ml (100 USP units/ml). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 07/23/24 at 1:51 p.m., LVN D said Resident #175 did not have the SASH documentation on the MAR for Resident #175's antibiotic. She said the MAR should have included the SASH documentation. LVN D said she was educated on IV administration and documentation with the yearly check offs in March or April. She said the potential negative outcome of the SASH documentation not in the MAR was a nurse may not flush the antibiotic in the correct order and the PICC line could clog and not be usable. She said she would add the SASH documentation cue into the computer system now, after surveyor intervention. During an interview on 07/23/24 at 2:12 p.m., the Corporate Nurse and Interim DON said the Unit Manager was responsible for ensuring the SASH documentation was in the computer system for all IV antibiotics and the DON was ultimately responsible. They said Resident #175's MAR should have included SASH documentation for her IV antibiotic. They said it was overlooked. The Interim DON said any resident with an IV or PICC line had a standing order to administer SASH per facility protocol and document in the MAR. He said the nursing staff were educated on the IV process and documentation at the annual skills fair 2 months ago. The Corporate Nurse said the potential negative outcome of the SASH documentation not in the MAR was a resident could potentially have a drug allergy. They said the expectation was for nurses to follow physician orders and IVs administered according to facility policy including documentation in the computer system. During an interview on 07/23/24 at 2:13 p.m., UM said Resident #175's MAR IV documentation should have included the SASH documentation. She said it was overlooked. She said the charge nurse was responsible for completing orders and it was her responsibility to double check orders for completion and accuracy. The UM said she was educated on order documentation including all correct orders put in place. The UM said the potential negative outcome of the SASH documentation not in the MAR was not following the plan of care. During an interview on 07/24/24 at 8:22 a.m., LVN A, said she was responsible for making sure the SASH order was in the computer system before she gave Resident #175 the IV antibiotic and she did not. She said she assumed the SASH order was in the computer system. She said the facility policy was to follow the SASH method when administering IV antibiotics and she gave the antibiotic according to policy. She said the IV SASH documentation was probably missed being entered in the computer system. LVN A said the process starts with the admission nurse, the other nurses should double check the orders and then the unit manager audits the orders for accuracy. She said then the DON audits orders for accuracy. LVN A said the potential negative outcome of the SASH documentation not in the MAR was a potential reaction to medication. Record Review of the facility's Physician's Orders policy dated January 2020 indicated, It is the policy of this facility that physician orders are maintained per state and federal regulations. 1. All physicians orders shall be recorded on the Patients Medical Record and must be signed electronically by the attending/ prescribing physician. 6. Medications, diets, therapy, or any treatment may not be administered to the patient without a written order from the attending physician.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for 1 of 9 dietary staff (Dietary Staff B) reviewed for competencies. The facility failed to ensure Dietary Staff B had a current Food Handlers Certificate while working in the facility's kitchen. This failure could place residents who consume food prepared in the facility kitchen at risk of foodborne illness due to being served by improperly trained staff. Findings included: Record review of 9 dietary staff food handlers certificates indicated Dietary Staff B's certificate was expired on [DATE]. During an interview on [DATE] at 11:00 a.m., the DM said Dietary Staff B had worked a day or two with an expired food handler certificate. During an interview on [DATE] at 11:30 a.m., the HR staff said the food handler certificate was important for the dietary staff to renew their food handler certificate to obtain the latest training to prevent food born borne illnesses and handle food correctly. During an interview on [DATE] at 2:00 p.m., the Administrator said all dietary staff must keep their dietary food handler certificates current. She said continued education was important to keep the dietary staff up to date with changes. During an interview on [DATE] at 9:00 a.m., Dietary Staff B said her food handler certificate had expired. She said she was not aware that she had to take the course every 2 years. Record review of the undated dietary staff list indicated 1 (Dietary Staff B) of 8 dietary staff had an expired food handler certificate. Record review of the punch detail for Dietary Staff B indicated she worked on [DATE], [DATE], [DATE], and [DATE]. Record review of the food handler certificate for Dietary Staff B indicated her food handler was expired on [DATE]. Record review of the new food handler's certificate for Dietary Staff B indicated it was obtained on [DATE] after survey began on [DATE]. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the policy dated [DATE] titled Licensure, Certification, and Registration of Personnel indicated Employees who require a license, certification or registration to perform their duties must present such verification with their application. 3. A copy of recertifications (annual, bi-annual, etc.,) as applicable must be presented to the human resource director/designee upon receipt of such recertifications and prior to the expiration of current licensure, certification, or registration. A copy of the recertification must be filed in the employee personnel record.