STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675625	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Nursing and Rehabilitation Center	4300 Vista Rd Pasadena, TX 77504

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215 Based on observation, interview, and record review, the facility failed to provide, based on the comprehensive assessment and care plan, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 1 of 6 residents (Residents #81) reviewed for activities, in that: The facility failed to ensure Resident #81 participated in one-on-one in-room activities since January 2024. This deficient practice could place residents at risk of decline in psychosocial well-being and their physical health. Findings included: Record review of Resident #81's Face Sheet dated 8/15/18 revealed she was an [AGE] year-old female admitted to the facility 2/24/23. Her diagnoses included cognitive communication deficit, ataxic gait (a walking abnormality that's characterized by an irregular, clumsy, and wide based walk), depression, muscle wasting and atrophy (loss of muscle mass and strength, often occurring due to lack of use, injury, malnutrition, or certain medical conditions, resulting in visible decrease in muscle size and function), and hyperthyroidism. Record review of Resident #81's MDS assessment dated [DATE] revealed a BIMS score of 6 indicating severe cognitive impairment. The activities rated as very important were listening to music and participating in religious services. Keeping up with the news, group activities, going outside, and doing favorite activities was rated as somewhat important. Record review of Resident #81's Care Plan dated 2/20/21 revealed she would attend socials and groups of interest. Resident would attend music, trivia, board games, Ice Cream Socials. Resident #81 required a rolling walker to attend. Interventions included inviting her to schedule activities and schedule medications, treatments, and ADL care around activities as able. Observation and interview on 11/19/2024 at 10:15 a.m., revealed Resident #81 lying in bed with the television on. A bed tray was hovering over her. She said she was tired of lying in bed. She said she had been at the facility for year and a half. She said they would come to visit her during mealtime. She said she never get out of bed unless it was to take a shower. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/20/2024 at 11:30 a.m., CNA A said she had been working at the facility since May 2024. She said she helped Resident #81 get up for showers. She said Resident #81 had a broken leg, broken hip, and whiplash. She said Resident #81 never wanted to get out bed. She said she tried to sit Resident #81 up to eat and sit her on the side of the bed, but she did not allow that to happen. She said Resident #81 refused food, therapy, and showers but would turn around and say staff had not done anything for her. She said when they tried to get Resident #81 out of bed, she would sometimes say she did not want to move her head. In an interview on 11/20/2024 at 11:36 a.m., the Activity Director said she always tried to do activities with Resident #81, but she refused. She said she had been working at the facility for [AGE] years. She said she had notes she could provide regarding Resident #81 refusal to participate in activities. The Activity Director tried looking for the refusal notes but could not find them. She said during the week, she would go into Resident #81's room and work with her. She said Resident #81 was an in-room patient. She said she had not done the books that keep logs of the resident's activties in a long time. She said she had not documented the weekly activities because she had not learned how to work the new software to document the activities that the residents participated in. She said she was going to call corporate because she did not understand the program. She said she should be documenting the activities that were usually done three times a week. She said it was important to have the activities documented to show the family and other staff at the facility what Resident #81 had been doing and what activities she participated in. She said she was out of work for 2 months and came back to the facility in September. She said the only activities she had to show for Resident #81 were progress notes of activities that were done every 90 days. In an interview on 11/21/2024 at 6:16 p.m., the Administrator said the Activity Director was not at the facility when the new system came about, and she was not able to save her documentation properly. He said it was important to have documentation of the resident's activities because it was a huge part of the resident's life. He said everyone should know what was being provided to the resident. He said it should all be captured. He said if daily activities were not provided to the residents, their mental capability could decline. He said everyone related well to stimulation. He said the activities with Resident #81 were done, but not documented in the system. Record review of the facility's policy titled Activity Program review date (not listed) read in part . Purpose: Provide a wide range of activities to enhance the lives of residents. Also, provide opportunities for residents and staff to interact on a social basis. Activities will be scheduled on a regular basis to enrich the lives of residents. Activities will include, but not be limited to: Social events, indoor and outdoor activities, activities away from the facility, religious programs, creative activities, intellectual and educational activities, exercise activities, individualized activities, in-room activities and community activities .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49710 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 preparation kitchen. The facility did not ensure the dishwasher was above the appropriate sanitizing temperature of 120 degrees Fahrenheit. This failure could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: In an observation on 11/20/24 at 1:30 pm, the low temperature dishwasher was observed at 115 degrees Fahrenheit during the rinse cycle, with 100 ppm. In an interview on 11/20/24 at 2:10 p.m., the Dietary Manager stated staff did not let her know the dishwasher was running low temperatures. Staff told her it was not for them to let her know . Maintenance came and looked at the water heater and he mixed up the heater with the laundry. There are two water heaters in the near closet located outside the kitchen. One is for the kitchen and the other one is for the laundry room. He raised it to 140 degrees Fahrenheit. She called corporate to ask where the temperature should be, and they stated between 120-140 degrees. They were checking the dishwasher temperatures multiple times a day so this could have been fixed sooner . She takes full responsibility. In an observation on 11/20/24 at 3:05 p.m., the dishwasher was observed running at 131 degrees Fahrenheit during rinse cycle. In an Interview on 11/20/24 at 3:10pm with the administrator. The interviewee states the dishwasher should be 120 degrees or above. He stated this was an older building and with the temperature dropping outside sometimes it takes longer for the water heaters to regulate. This old building is not as stable as it used to be. The Dietary Manager thought 115 degrees was okay. He stated he called three other facilities and spoke with them, and they thought 115 degrees would be sufficient since we use disinfectant solution as well and not relying on just the hot water. He stated it is the responsibility of the dietary staff to be checking the dishwasher daily. He stated he would be happy to have something in place for admin to be a backup for checking the temperature logs. Record review of an undated google document provided by the Administrator read in part, .Dishwashers that rely on chemicals to sanitize should reach a minimum of 120 degrees Fahrenheit, dated October 29, 2024 .

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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 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** 38644 47722 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #67 and Resident #88) of 5 residents reviewed for infection control. 1. CNA F did not wear appropriate PPE when helping Resident #67, a resident on Enhanced Barrier Precautions, transfer from wheelchair to bed. 2. LVN G did not wear appropriate PPE when she was giving Resident #88, a resident on Enhanced Barrier Precautions, medications through his G-tube (tube into stomach for nutrition). These failures could place residents at risk for cross-contamination, and the spread of infection. Findings include: 1.Record review of Resident #67's undated face sheet revealed he was an [AGE] year-old male admitted on [DATE] with diagnoses of dementia (a decline in mental ability that affects a person's daily life), and retention of urine (unable to empty bladder). Record review of Resident #67's Admission MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15, which indicated normal cognition. The resident used a wheelchair for mobility and required partial to moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with chair to bed transfers. According to the MDS, the resident had an indwelling catheter (a tube into the bladder to drain urine). Record review of Resident #67's care plan dated 11/7/24, revealed a Focus: Resident has a foley catheter at risk for UTI, and other complications r/t urinary retention (Initiated: 11/7/24, Revised: 11/14/24). Goal: Foley catheter will remain patent through review date (Initiated: 11/14/24 Target: 11/20/24). Interventions: Change foley tubing and bag as ordered. Change foley catheter Q month and as needed. Catheter care per facility and PRN. Focus: Resident has an indwelling medical device. This places them at an increased risk of transmission of MDRO's (Initiated: 11/20/24, Revised: 11/20/24). Goal: Residents dignity and privacy will be maintained (Initiated: 11/20/24, Target: 11/20/24). Interventions: Change PPE before caring for other residents. PPE will be used for the following situations during resident care: dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, or assisting with toileting. Record review of Resident #67's Physician Orders revealed the following orders from MD C: - Change Foley catheter monthly on the 15th and PRN for occlusion/leaking. May flush with 30-60cc saline PRN occlusion. (16 Fr size and 10-30 balloon CC). Ordered on 11/7/24 at 2:00am. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Enhanced Barrier Precautions - gown and gloves required for high-contact activities: dressing, bathing, transfers, providing hygiene, changing linens, incontinent care, toileting, therapy, device care (catheter, central line [a tube inserted into a large vein], feeding tube or trach [opening into neck for an airway]), and wound care. Every day and night shift. Ordered on 11/7/24 at 11:30am. Record review of Resident #67's November 2024 MAR-TAR revealed staff signed off that the resident was on EBP for day and night shifts from 11/7/24-11/21/24. In an observation and interview on 11/20/24 at 9:12am, CNA F helped transfer Resident #67 from his wheelchair into his bed without any PPE on. Above the resident's bed was a sign with EBP on it. CNA F said the EBP meant they were supposed to wear the blue gowns with resident care. She said she was supposed to have worn the PPE, but she did not have any with her and that was why she did not put it on. She said she had just taken the resident from the dining room, and she did not have any PPE with her. She said they kept the PPE in the supply room. CNA F said she usually kept a couple gowns in her pocket, and they were not supposed to keep any in the room. The CNA said she was not from that hall but knew which of her residents were on EBP and so she would grab some PPE before going in their room. She said if the PPE was not worn it would cause infection control problems. In an interview on 11/20/24 at 9:20am with LVN G, she said they kept PPE in the supply closet. She said the staff knew which residents were on EBP so before going in the resident's room they grabbed PPE. The LVN said if they were in the room and figured out, they needed PPE, they could get some from the med cart or go to the supply room to grab some. She said they were unable to stock up on PPE at the beginning of the shift and keep it on them. She also said they were not allowed to keep any PPE in the resident's room. In an interview on 11/20/24 at 10:50am with LVN G, she said they could keep gowns in the drawers of the resident's rooms, they just could not have the gowns visible. 2.Record review of Resident #88's undated face sheet revealed he was a [AGE] year-old male originally admitted on [DATE], with the most recent admission being 10/23/24. He had diagnoses of dysphagia following cerebral infarction (trouble swallowing after a stroke) and gastrostomy status (opening into the stomach from the abdominal wall for nutrition). Record review of Resident #88's Significant Change MDS assessment from 10/25/24 revealed a BIMS score of 13 out of 15, which indicated normal cognition. The resident was dependent with all ADLs. The MDS revealed the resident was coughing or choking during meals or when swallowing medications and complained of difficulty or pain with swallowing. It also revealed he was on a feeding tube (tube into stomach for nutrition) on admission and while a resident. Record review of Resident #88's care plan dated 5/13/24 revealed a Focus: Resident is NPO and has a G-tube (tube into stomach for nutrition) for nutrition and hydration due to dx of dysphagia (Initiated: 5/14/24, Revised: 5/14/24). Goal: G-tube will remain patent through next review date (Initiated: 5/14/24, Target: 1/23/25). Interventions: Enhanced barrier precautions, gown and gloves required for high contact activities. Focus: Resident has indwelling medical devices. This places them at an increased risk of transmission of MDROs. Resident has the following indwelling medical device: feeding tube (Initiated: 5/22/24, Revised: 8/28/24). Goal: Residents dignity and privacy will be maintained (Initiated: 5/22/24, Target: 1/23/25). Interventions: PPE will be used for the following situations during resident care: .providing hygiene, transferring . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #88's Physician Orders revealed the following orders from MD C: - Enhanced Barrier Precautions - gown and gloves required for high-contact activities: dressing, bathing, transfers, providing hygiene, changing linens, incontinent care, toileting, therapy, device care (catheter, central line, feeding tube or trach), and wound care. Every day and night shift. Ordered on 10/23/24 at 10:02pm. - NPO-Tube feeding diet. Ordered on 10/23/24. - Enteral feed (feeding into the intestine), Jevity 1.5 (type of feeding) 55ml/hr x 22hours, off at 6am. Ordered on 11/11/24 at 8:09am. Record review of Resident #88's November 2024 MAR-TAR revealed staff signed off that the resident was on EBP for day and night shifts from 11/1/24-11/21/24. Record review of Resident #88's Kardex from 11/21/24 revealed he was on Enhanced Barrier Precautions and gown and gloves were required for high contact activities. An observation and interview on 11/20/24 at 3:01 p.m. in Resident #88's room revealed a sign above his bed that read EBP. LVN B washed her hands and donned gloves, but did not don a gown. She began the medication administration via g-tube for Resident #88 which included checking for placement and administering the medication and water flushes via feeding tube. After medication administration, LVN B said Resident #88 was on enhanced barrier precautions and said she needed to wear a gown for residents with g-tubes and wounds. She said she was trying to be perfect and putting on the gown slipped her mind. She said she was trained on EBP during orientation and the purpose was to protect the resident from infection. She said the resident could be at risk of transferring whatever was on the staff to them. In an interview with the DON on 11/21/24 at 10:20am, she said her expectations for staff and EBP was they were to wear a gown, gloves, and a face shield if needed. She said they should wear it with any resident care and could get the PPE from the supply room or from the drawers in the resident's room. The DON said the signs are above the resident's bed in their room. She said staff knew which residents are on EBP because they work the same halls and know their residents. She said staff are supposed to wear PPE to protect themselves and the residents from infection. The DON said if they did not wear PPE it was an infection control issue. She said the solution to having CNAs from other halls not knowing which residents were on EBP and needing PPE, was to have the PPE in the resident's drawers so they would not have to run out of the room to grab PPE. The DON said, or in the situation that happened earlier, they can grab PPE out of the resident's drawer and put it on quickly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated policy and procedure on Enhanced Barrier Precautions reflected in part: .EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Guidance: EBP are indicated for residents .with chronic wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Indwelling medical device examples: central lines, urinary catheters, feeding tubes .Procedure: For resident for whom EBP are indicated should employ EBP during the following high-contact resident care activities: .transferring .device care or use: .feeding tube .