

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  University Place Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7480 Beechnut Houston, TX 77074	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918</b></p> <p>Based on observations, interviews and record review, the facility failed to ensure residents receive services in the facility with reasonable accommodation of resident needs for 1 of 5 residents (Resident #7) reviewed for call lights.</p> <p>The facility failed to have a call light within reach for Resident #7.</p> <p>This failure could place residents at risk for a delay in care and services, increased falls, and a decreased quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #7's face sheet dated 09/12/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #7 had diagnoses which included: Major depressive disorder (mental health condition that can cause a person to feel persistently low and loss of interest in activities), hypertension (pressure in the blood vessels is always higher than normal), and dementia (decline in mental and physical abilities that interferes with daily life).</p> <p>Record review of Resident #7's quarterly MDS assessment dated [DATE] revealed a BIMS score of 08 of 15 which indicated moderately impaired cognition. Further review revealed the resident needed partial to moderate assistance with ADLs which required at least one staff assistance.</p> <p>Record review of Resident #7's care plan initiated on 12/26/16 revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff.</p> <p>During an observation and interview on 09/10/24 at 10:40 a.m., revealed Resident #7's call light was tied up and was placed close to the wall by the insertion site(outlet from the wall). Resident #7 asked the surveyor if she could find her call light, and the surveyor pointed to the wall by Resident #7's bed. Resident #7 tried to reach for the call light but could not. The surveyor stepped out of the room and called the IP to assist Resident #7.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 09/10/24 at 10:42 a.m., the IP said she saw Resident #7's call light was tied up and close to the wall. The IP said Resident #7's call light was supposed to be within reach. The IP said Resident #7 used the call light to reach staff if Resident #7 needed help. The IP said Resident #7 could fall if she could not reach the call light.</p> <p>During an interview on 09/10/24 at 11:08 a.m., LVN A said Resident #7's call light should be within reach. LVN A said the resident uses the call light to call for assistance. LVN A said if Resident #7 could not reach the call light, Resident #7 could try to get up and fall. LVN A said the nurse monitored the aides during rounding.</p> <p>During an interview on 09/10/24 at 12:17 p.m., CNA D said the call light should be within reach for Resident #7, and she made rounds every two hours. CNA D said she placed the call light within reach for Resident #7 when she made rounds and did not know who tied up the call light string. CNA D said if Resident #7's call light was not within reach and Resident #7 needed help, then there would be delayed care, and if Resident #7 was choking and could not reach the call light, she might pass out or Resident #7 would fall if she tried to get up. CNA D said she had in-service on-call lights, and the nurses monitored the aides during rounding.</p> <p>During an interview on 09/12/24 at 10:06 a.m., the DON said CNA D should place the call light within reach of Resident #7 so Resident #7 could reach it and use it when she needed assistance. The DON said that if Resident #7 could not reach the call light and get help, Resident #7 could try to get out of bed and fall. The DON said the nurse monitored the aides when the nurse made rounds. The DON said the unit manager monitored the nurses when he made rounds and ensured the nurses were checking on the aide while providing any care.</p> <p>During an interview on 09/12/24 at 10:56 a.m., the CM said the expectation was the call light should be always within Resident #7's reach, whether in a chair or bed. The CM said he had the call light was tied up and by the wall for Resident #7, but the call light should always be within reach. The CM said there would be a tendency for Resident #7 to fall if the resident could not reach the call light. The CM also said Resident #7 could not get the staff on time in an emergency. The CM said the CNA and the nurse were responsible for making sure the call light was within reach. The CM said that all staff should report when the call light was not within reach of any resident. The CM said the nurses were responsible for ensuring the aides were doing their tasks. The CM said the clinical manager and the DON monitored the nurses during rounding.</p> <p>Record review of the facility policy on call system dated August 27, 2024, read in part . purpose . Residents are provided with a means to call staff for assistance through a communication system that directly causes a staff member or centralized working station . statement #1 . each resident is provided with a means to call staff directly for assistance from his /her bed from toileting/bathing facilities and from the floor .</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32422</p> <p>Based on interview and record review the facility failed to electronically transmit encoded, accurate, and complete MDS data to the CMS System within 14 days after completing a resident's assessment for 1 (CR#1) 1 resident reviewed for transmitting MDS assessments to CMS.</p> <p>-The Facility failed to complete and transmit a discharge MDS assessment for CR #1.</p> <p>This failure could place residents at risk of not having accurate and complete information available to those providing their treatment and care.</p> <p>Findings included:</p> <p>Record review of Resident CR #1's face sheet dated [DATE] indicated he was [AGE] years old admitted on [DATE] for diagnoses that include fall, initial encounter (the first time a provider evaluates a fall injury or condition) and Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). The face sheet had a discharge date of [DATE].</p> <p>Record review of CR #1's Discharge MDS assessment dated [DATE] indicated CR #1 was discharged , return not anticipated. CR #1 had a BIMS score of 7 which indicated he had severely impaired cognition. The MDS assessment had a status of completed but not accepted in transmission to CMS.</p> <p>Record review of CR #1's Care Plan dated[DATE] indicated care plans to address falls and cognitive loss/Dementia.</p> <p>Record review of CR #1's Social Services Notes Progress Notes dated [DATE] revealed that CR #1 discharged to an Assisted Living Facility.</p> <p>Record review of transmittal page confirming the discharge MDS was accepted on [DATE] to CMS.</p> <p>During an interview on [DATE] at 10:51 am, with the MDS Coordinator/RN, she said that she had a team's meeting on the evening of [DATE] after the Administrator and DON notified her of the missed MDS assessment. She said unfortunately this MDS was missed and showed the surveyor a copy and explained that it was checked complete but not submitted until yesterday. The MDS/RN said that she is over MDS assessments but does have a colleague. She said the facility was in the process of changing from their current EMR to a different one that would flag issues like this to avoid missing the transmittal to CMS, she added that she used the RAI manual for the policy and procedure. When asked what a negative impact on the resident could be if the MDS assessments were not submitted within the time frames by CMS, she added that the MDS assessment communicated the status of a residents' health status and needs and this was important to reflect care needs or progress.</p> <p>During an interview on [DATE] at 11:00 am, the DON said that the facility met over the missed MDS and were in the process of addressing the tracking and missed transmittal to CMS.</p> <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE], time unknown with the Administrator, he confirmed the meeting to address the missed MDS and confirmed that the missed MDS assessment was transmitted to CMS last night ([DATE]) and that the facility was addressing the missed MDS assessment to avoid missing any assessments in the future.</p> <p>Record review of facility provided CMS's RAI Version 3.0 Manual, Chapter 5: Submission and Correction of The MDS Assessment revised ,d+[DATE] revealed:5.1 Transmitting MDS data- All Medicare and/or Medicaid-certified nursing facilities or agents of those facilities must transmit required MDS data records to CMS. 5.2 Timeliness Criteria- completion timing. For all other comprehensive MDS assessments, Annual assessment updates. the completion may be no later than 14 days from the ARD. Upon a resident's entry, discharge to community, discharge to another facility or discharge deceased , a subset of items but be completed within 7 days of the Event Date.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36918</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident #64) reviewed for incontinent care.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure CNA Z did not place the foley bag on the bed during foley catheter care for Resident #64.</li> <li>The facility failed to ensure CNA G separated Resident #64's labia, cleaned the foley catheter insertion site and performed proper hand hygiene during foley care for Resident #64.</li> </ol> <p>These failures could place residents at risk for pain, infection, injury, and hospitalization .</p> <p>Findings included:</p> <p>Record review of Resident #64's face sheet dated 09/12/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #64 had diagnoses which included: dementia (loss of mental functions that affects daily life activities), hypertension (pressure in the blood vessels is always higher than normal), and fracture of part of neck of right femur (a break in the top of the thigh bone, just below the hip joint).</p> <p>Record review of Resident #64's admission MDS assessment dated [DATE] revealed a BIMS score of 10 of 15 which indicated moderately impaired cognition. Further review revealed the resident had a foley catheter.</p> <p>Record review of Resident #64's care plan initiated on 08/29/24 revealed resident noted with a foley catheter due to urinary retention and at risk for infection. Intervention: Keep tubing and bag below the bladder, and do not kink tubing.</p> <p>Record review of Resident #64's order listing report read in part .foley catheter care each shift, document output every shift for urinary retention start date 09/05/24 .</p> <p>During an observation on 09/11/24 at 1:16 p.m. of Resident #64, foley care provided by CNA G and CNA Z. CNA Z placed Resident #64's foley bag on the bed at the same level as the resident's bladder, from 1:20 p. m. to 1:38 p.m which had small amount yellow urine. CNA G wiped the resident's buttocks three times and when CNA G ran out of wipes, she opened another wipe packet and pulled wipes from the packet with the same gloves she had used to clean Resident #64's buttocks. CNA G did not separate the labia or clean the foley insertion site. CNA G did not hold the foley French( part of the tubing inserted into a resident ) when she cleaned it to prevent the foley French from pulling.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/11/24 at 1:50 p.m., CNA G said she thought she had changed her gloves before opening the clean wipe after she had wiped Resident #64's buttocks. CNA G said she should have changed her gloves when going from dirty to clean because of cross-contamination. CNA G said she thought she separated the labia and cleaned it. CNA G said if the labia were not separated, it may not be cleaned well, and it would be an infection control risk because the resident could get an infection. CNA G said CNA Z placed the Foley bag on the bed throughout care so they would not pull on the tube. CNA G said she did not secure the Foley when she cleaned the small tube, and she did not clean the insertion site because she did not separate the labia. CNA G said she had in-service on Foley care and was told not to place the Foley bag on the bed at the same level so that the urine would flow through gravity. CNA G said if the urine flowed back into Resident #64's bladder, the resident could get an infection.</p> <p>During an interview on 09/11/24 at 1:56 p.m., CNA Z said CNA G did not separate Resident #64's labia, and CNA G did not hold the tubing while she cleaned it to prevent the tubing from pulling. CNA Z said CNA G opened the clean wipes with the dirty gloves, but CNA G should have removed the dirty gloves, washed or sanitized her hands, and donned clean gloves before opening the wipe packet.</p> <p>During an interview on 09/11/24 at 2:00 p.m., CNA Z said she placed the Foley bag on the bed, but she should not have because the urine would flow back into Resident #64's bladder. CNA Z said Resident #64 could get a UTI. CNA Z said she had in-service and training on foley care. CNA Z said the nurse monitored the aide during rounding.</p> <p>During an interview on 09/12/24 at 12:00 p.m., the DON said Resident #64's foley bag should always be below the bladder for the urine to drain through gravity. The DON said the CNA should not have placed the foley bag on the bed at the bladder level because the urine would have flowed back into the bladder, and Resident #64 could have had an infection (UTI). The DON said CNA G should have separated Resident #64's labia and cleaned the insertion site, and if the labia was not appropriately cleaned, Resident #64 could also get an infection. The DON said CNA G should have held onto the French while she cleaned it to prevent it from pulling, which could hurt Resident #64. The DON said CNA G should have washed or sanitized her hands when she went from dirty to clean, and CNA G contaminated the clean wipes.</p> <p>Record review of the facility policy on hand hygiene dated 5/27/24 read in part . purpose . Effective hand hygiene removes transient microorganisms, dirt, and organic material from the hands and decreases the risk of cross contamination to patients, patient care equipment and the environment . policy statement . HCWs will perform hand hygiene following the guide for hand hygiene product use when:</p> <ol style="list-style-type: none"> <li>a. Entering and exiting patients' rooms. (This will be the measure of hand hygiene compliance.)</li> <li>b. Before donning sterile or non-sterile gloves</li> <li>c. Before performing invasive procedures or handling an invasive device.</li> <li>d. Before handling medications.</li> <li>f. After contact with body fluid or excretions, mucus membranes, non-intact skin or wound dressings whether or not gloves were worn.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>g. If moving from a contaminated body site to another body site during the care of the same patient.</p> <p>h. After contact with inanimate surfaces and objects in the patient room/care area.</p> <p>i. After removing sterile or non-sterile gloves.</p> <p>Record review of the facility isolation policy dated 11/16/21 read in part . statement #2. The use of transmission-based precaution is to prevent the spread of certain infectious agents, which required additional precautions beyond standard precautions .</p> <p>Record review of the facility policy on perineal care dated 09/12/24 read in part . purpose . the purpose of this procedure are to provide cleanliness and . to the resident, to prevent infection . procedure #6. For female resident . separate labia and clean downward from front to back . if the resident had an indwelling catheter, gently clean the juncture of the tubing from urethra down the catheter about 3 inches .</p>

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36918</p> <p>Based on observation, interview and record review the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 (Resident #14) residents reviewed for intravenous fluids.</p> <p>The facility failed to ensure LVN A removed bubbles from the IV tubing, removed air from the syringe and flushed the PICC line before IV medication administration for Resident# 14.</p> <p>An IJ was identified on 09/26/24. The IJ template was provided to the facility on [DATE] at 5:59 p.m. While the IJ was removed on 09/27/24 at 9:40 p.m. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated due to the facility need to evaluate the effectiveness of the corrected system.</p> <p>This deficient practice could place residents at risk for serious harm, injury, or death by introducing air into an PICC line which could cause an air embolism (bubbles trapped in a blood vessel that can block blood flow).</p> <p>Findings include:</p> <p>Record review of Resident #14's face sheet dated 09/12/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses which included: diabetes mellitus (the body cannot control the amount of sugar in the blood), hypertension (pressure in the blood vessels is always higher than normal), and heart failure (when heart is unable to pump enough oxygenated blood to meet the body's needs).</p> <p>Record review of Resident #14's admission MDS assessment dated [DATE] revealed a BIMS score of 13 of 15 which indicated intact cognition. Further review revealed the resident needed moderate to extensive assistance with ADLs which required at least one staff assistance. Further review did not reflect Resident #14 was on IV medication.</p> <p>Record review of Resident #14's care plan initiated on 07/28/24 revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff. Further review reflected the resident was on IV antibiotic therapy related to infection osteomyelitis of the right toe. Intervention: administer medication as ordered.</p> <p>Record review of Resident #14's clinical physician orders read in part . PICC/CENTRAL LINE (Peripherally Inserted Central Catheter): flush with 10 CC NS each shift before medication administration .order date 07/25/24 . meropenem intravenous solution reconstituted 500mg every 12 hours for osteomyelitis(bone infection ) for 2 weeks start date 09/04/24 .</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 09/11/24 at 6:52 a.m., LVN A administered IV meropenem 500 mg intravenously to Resident #14, who was lying in bed on his back. LVN A went into the medication room, brought the medication and the tubing, and placed the medication at the nursing station. LVN A broke the medication seal, spiked the medication bag with the tubing, hung it on the IV pole, and cleaned Resident #14's port. After LVN A cleaned Resident #14's port, he opened the clamp, and the medication flowed into the tubing. There were numerous bubbles in the tubing a few inches below the chamber and at intervals throughout the tubing. LVN A was about to connect the tubing to the port on Resident #14's arm when the surveyor intervened. LVN A said he was moving too fast and should have primed the medication and removed all the bubbles. LVN A primed the tubing and removed the bubbles. LVNA was about to connect the tubing to Resident #14's port without flushing the port, and the surveyor intervened. LVN A opened the flush and was about to flush Resident #14's port, but he did not remove the air in the flush. LVN A was about to insert the flush syringe into Resident #14's port when the surveyor intervened, and he primed the flush and administered the medication.</p> <p>During an interview on 09/11/24 at 3:54 p.m., LVN A said he did not realize the IV line had bubbles, and if he had administered the IV medication with bubbles, he could have caused Resident #14 to have an air embolism (bubbles trapped in a blood vessel that can block blood flow) . LVN A said he did not take out the air in the flush, and it was unsafe for Resident #14 because that would be air going through Resident #14's vein. LVN A said he had training in IV medication administration, and the DON and clinical manager monitored the nurses during rounding.</p> <p>During an interview on 09/12/24 at 11:55 a.m., The DON said LVN A should have ensured all the air was out of the tubing before he hooked up to Resident #14's port. The DON said LVN A should have primed the IV line to prevent air embolism and pain. The DON said LVN A should have flushed the port before administering the medication. The DON said the line should be flushed to make sure the line was patent (open and unobstructed free passage) and there was no clot or infiltration.</p> <p>During an interview on 09/26/24 at 2:55 p.m., LVN A said the facility provided in-services in the last month, and he did skills check-off, but the facility did not provide a certificate. LVN A said he never did a training that issued an IV administration certificate.</p> <p>During an interview on 09/26/24 at 3:27 p.m., the DON said their contract pharmacy had done the nurse's IV Training. Still, the pharmacy representative told her he could not locate any training for facility nurses from 2021 to the present. The DON said RNs and LVNs should have an IV Administration Certificate before administering their first IV and be monitored during their first IV administration. The DON said she did not know if the IV Certificate was a requirement with the facility, State, or Board of Nursing, but she would look into it.</p> <p>During an interview on 09/26/24 at 3:53 p.m., the NP said she did not get a call from the facility about LVN A's attempt to administer IV medication with bubbles in the line and not flushing the line before administering the medication. The NP said LVN A should have primed the tubing and made sure there were no bubbles in the line, if the bubble was big(3mm), then the bubble could cause respiratory distress, air embolism. The NP said LVN A should have pushed out the air from the flush syringe before he attempted to flush Resident #14's port, which was done to make sure the line was patent. The NP said 3mm of air could be bad for Resident #14.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/26/24 at 3:58 p.m., the Educator said IV certification was not required, but nurses are checked off on IV medication skills. The Educator said IV monitoring and staff rounding should be done randomly and periodically by the CM and the DON. The Educator said if issues are observed, the facility will go back and look at where the nurse had a hard time with skills, and the nurse would be retrained.</p> <p>During an interview on 09/27/24 at 10:59 a.m., the DON said the system breakdown happened when LVN A did not follow the correct procedure of IV medication administration because he did not lock the IV tubing before he spiked the IV medication bag. The DON said it caused the medication to flow fast, and bubbles formed in the tubing. The DON said LVN A should have primed the tube until he expelled the bubbles from the tube before he attempted to administer the medication to Resident #14.</p> <p>During an interview on 09/27/24 at 9:30 p.m., the Administrator and DON, the Administrator said there was a break when LVN A did not follow the proper procedure for IV medication. The Administrator stated LVN A was nervous, and LVN A goofed, which caused the error in the IV medication administration procedure.</p> <p>Record review of the facility intravenous medication administration skills - check off dated 11/01/23 revealed LVN A was trained on IV medication administration.</p> <p>Record review of the facility medication and treatment order dated 12/15/24 read in part purpose . to ensure accurate, safe, and effective administration of prescribed medications . policy statement #21 . intravenous Orders: Will specify the type of solution, rate of flow, and volume to be infused .</p> <p>Record review of the facility IV medication administration policy dated 09/27/24 read in part . procedure #4 . prime new administration set, including add - on devices and tubing . #4b . remove cap from the tubing, open roller clamp to prime tubing, then hold the distal end of the tubing over sink, or trash can (keep the tip sterile) and allow all of the air bubbles to leave the tubing . #4c . ensure that no air bubble remain in tubing .</p> <p>Record review of the Texas board of nursing practice read . It is the opinion of the Board that the LVN shall not engage in IV therapy related to either peripheral or central venous catheters, including venipuncture, administration of IV fluids, and/or administration of IV push medications, until successful completion of a validation course that instructs the LVN in the knowledge and skills applicable to the LVN's IV therapy practice. The BON does not define or set qualifications for an IV Validation Course or for LVN IV certification. The LVN who chooses to engage in IV therapy must first have been instructed in the principles of IV therapy congruent with prevailing nursing practice standards .</p> <p>This was determined to be an Immediate jeopardy (IJ) on 09/26/24 at 5:59 p.m. The Administrator, Senior [NAME] President, DON and [NAME] Present for Post - Acute Care, was notified. The Administrator was provided with the IJ template on 09/26/24 at 5:59p.m.</p> <p>The following Plan of Removal was accepted on 09/27/24 at 12:26p.m. a.m. PLAN OF REMOVAL</p> <p>Facility Name</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  University Place Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7480 Beechnut Houston, TX 77074	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediate Jeopardy Plan of Removal</p> <p>Annual Survey Completed: 09/11/2024</p> <p>Survey Reopened: 09/26/2024</p> <p>Notice of IJ: 09/26/2024</p> <p>F-694 Parenteral Fluids / IV Fluids</p> <p>The facility has implemented the following Plan confirming systems are in place to ensure that the nursing staff have and demonstrate competency skill sets necessary to safely administer parenteral/intravenous (IV) medications including, but not limited to, checking for contraindications to ordered IV medication; confirming that the correct medication is selected with the appropriate concentration and dosage; practicing strict sterile technique when preparing and administering the IV medications; verifying correct IV equipment is used; completing hand hygiene; priming the IV tubing and ensuring there are no air bubbles in the line; inspecting the IV insertion site for signs of infection and infiltration; disinfecting the IV insertion site; flushing the IV site prior to connecting the tubing with the IV medication; administering medications at the prescribed rate to avoid complications; documenting correct information; and reporting. For further details, see No. 4 below.</p> <p>Immediate Action:</p> <p>Document here the action taken by the facility to ensure there are no residents in jeopardy or threat of harm. This could include assessing residents, reviewing records, assessing environmental concerns, providing training to immediate staff. Date each task and if needed when task will be completed and who is responsible for completing the task (if a contractor or supplies need to be coordinated what day the service or goods are available to the facility).</p> <p>1. The facility initially undertook corrective action with regards to Resident #14. The facility confirmed that Resident #14 was discharged from the facility on September 24, 2024. At the time of the survey, and after prompting by the Surveyor, the involved LVN administering Resident 14's IV medications correctly primed the IV tubing, flushed the IV, and correctly administered the ordered IV medication.</p> <p>2. After being alerted by the surveyor to what happened, the Director of Nursing immediately performed just-in-time education on the appropriate procedure for administering IV medications with the involved LVN, who successfully demonstrated the correct procedure to administer IV medications.</p> <p>3. The facility reviewed and revised its clinical guideline entitled Central Venous Access, Peripherally Inserted Central Catheters, Implanted Access Ports, and Peripheral Venous Access - Nursing Center to include more detail about the administration of IV medications. The facility also developed an IV Administration Checklist to include the step-by-step process for administration of IV medications. This updated process includes:</p> <p>Process: 1. Equipment and Supplies</p> <p>Steps</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Non-sterile gloves;</p> <p>2. Infusion administration sets (tubing and add-on devices);</p> <p>3. Add-on devices:</p> <ul style="list-style-type: none"> <li>o Catheter end cap, injection port;</li> <li>o Filters (if necessary);</li> <li>o Stopcock; and</li> <li>o Extension tubing.</li> </ul> <p>4. Infusate solution; and</p> <p>5. Alcohol pads.</p> <p>2. Assessment: Inspect intravenous catheter for any signs/symptoms of IV related complications at scheduled intervals. Observe equipment for sterility or problems.</p> <p>3. Steps in the Procedure: Perform Hand Hygiene</p> <p>Prepare equipment:</p> <ul style="list-style-type: none"> <li>a. Attach add-on devices to administration set;</li> <li>b. Clamp new administration tubing;</li> <li>c. Spike access site of infusate container with new administration set; and</li> <li>d. Hang infusate from IV pole.</li> </ul> <p>Prime new administration set, including add-on devices and tubing:</p> <ul style="list-style-type: none"> <li>a. Squeeze drip chamber to fill according to manufacturer's instructions (1/3 to 1/2 full);</li> <li>b. Remove cap from tubing, open roller clamp to prime tubing, then hold distal end of tubing over sink or trash can (keep tip sterile) and allow all of the air bubbles to leave tubing;</li> <li>c. Ensure that no air bubbles remain in tubing; and</li> <li>d. When primed, clamp tubing and replace cap.</li> </ul> <p>Don clean non-sterile gloves.</p> <p>Connecting new tubing:</p> <p>(continued on next page)</p>

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. Disinfect catheter hub with antiseptic solution (usually alcohol);</p> <p>b. Remove cap from distal end of new tubing;</p> <p>c. Attach primed tubing to catheter access cap; and</p> <p>d. Secure connection by screwing tubing into catheter access cap. Tape connections if needed for extra security.</p> <p>Resume Infusion:</p> <p>a. Unclamp catheter;</p> <p>b. Open roller clamp;</p> <p>c. Check pump program or flow regulator device for proper rate/volume; and</p> <p>d. Observe flow rate for 1-2 minutes to ensure accuracy.</p> <p>Discard used supplies.</p> <p>Remove gloves and perform hand antisepsis.</p> <p>Label administration set and tubing with date, time and initials.</p> <p>4. Documentation: 1.The date and time of the administration set change. 2. The type of flow-control device. 3. The type of solution or medication infusing. 4.The amount of solution or medication to be infused.</p> <p>5.The rate of infusion. 6.The condition of the IV site. 7. Notification of the physician of any intravenous complications. 8.Resident's response to treatment. 9. The signature and title of the person recording the data.</p> <p>5. Reporting 1.Notify physician, supervisor and oncoming shift of Resident refusal of procedure or any complications.</p> <p>2. Report other information in accordance with facility policy and professional standards of practice.</p> <p>1. The facility is using the IV Administration Checklist to evaluate staff competency on IV medication administration.</p> <p>2. The Director of Nursing/Designee re-educated all nursing staff on the revised clinical guideline entitled Central Venous Access, Peripherally Inserted Central Catheters, Implanted Access Ports, and Peripheral Venous Access - Nursing Center to include the step-by-step process for the administration of IV medications.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Utilizing the newly developed IV Administration Checklist, the Director of Nursing/Designee re-educated nursing staff on the process for administering IV medications as outlined in No. 3 above. No staff will be allowed to schedule shifts without first completing this re-education with demonstrated competency.</p> <p>4. All newly employed nursing staff will be educated on IV medication administration utilizing the Guideline and the newly developed IV Administration Checklist.</p> <p>5. Annually all nursing staff will undergo competency validation for IV medication administration.</p> <p>***The effectiveness of the re-education and the competency of the nursing staff will be measured by reviewing fallouts from the audits performed by the Director of Nursing/Designee and providing just-in-time re-education of the staff member responsible for the fallout. Also, for identified areas of non-compliance, staff members will be re-educated in mandatory staff meetings held monthly. Attendance at these meetings will be tracked.</p> <p>***All staff members will be educated on the process for IV medication administration described above before being allowed to work a shift.</p> <p>Completion Date: September 27, 2024</p> <p>Facility's Plan to Ensure Compliance Quickly:</p> <p>How will the facility ensure compliance efficiently and timely? This could involve developing policies and procedures, training staff, repairing equipment, contacting physicians, having a QAIP meeting, developing forms, making repairs, or developing a new system. Be sure to document who provides the training, dates of training and how competency of staff of learning and training (return demonstrations, testing, competency checks). Please make sure dates of trainings are documented and if staff involvement is required that the staff member will not assume any job responsibilities until training has been received by them. Please make sure all audits, policies, notifications or services provided by outside contractors to remove the potential harm are dated.</p> <p>1. The Director of Nursing immediately performed just-in-time education on the appropriate procedure for administering IV medications with the involved LVN, who demonstrated competency in the procedure.</p> <p>2. The facility reviewed and revised its clinical guideline entitled Central Venous Access, Peripherally Inserted Central Catheters, Implanted Access Ports, and Peripheral Venous Access - Nursing Center to include more detail on the administration of IV medications.</p> <p>3. The facility developed a new IV Administration Checklist to evaluate staff competency on IV medication administration.</p> <p>4. The Director of Nursing/Designee re-educated all nursing staff on the revised clinical guideline entitled Central Venous Access, Peripherally Inserted Central Catheters, Implanted Access Ports, and Peripheral Venous Access - Nursing Center to include the step-by-step process for the administration of IV medications.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5. Utilizing the newly developed IV Administration Checklist, the Director of Nursing/Designee re-educated nursing staff on the process for administering IV medications as outlined in No. 3 above. No staff will be allowed to schedule shifts without first completing this re-education with demonstrated competency.</p> <p>What program will be put into place to monitor the continued effectiveness of the system changes?</p> <ol style="list-style-type: none"> <li>1. There will be daily observation by the Clinical Educational Specialist/Nursing Manager/Designee of 100% of IV medication administrations for 30 days with 100% compliance.</li> <li>2. For days thirty-one (31) to ninety (90), the Clinical Educational Specialist/Nursing Manager/Designee will perform random observations of IV medication administration weekly to confirm sustained compliance.</li> <li>3. During monthly QAPI Committee meetings, the IDT team will review the results of the observations/audits performed by the Clinical Educational Specialist/Nursing Manager/Designee and follow-up monthly to ensure adherence to policies/procedures. PIPs will be developed to address any areas of concern.</li> </ol> <p>Completion Date: September 27, 2024</p> <p>Responsible Person: Director of Nursing/Designee</p> <p>Surveyor monitored the plan of removal for effectiveness as follows:</p> <p>Record review of the facility just in time training revealed the DON did one on training for LVN A on 09/11/24 on IV medication administration and he returned demonstration.</p> <p>Record review of the facility policy on clinical guideline for central venous access peripherally inserted central catheter, implanted access port, and peripheral venous access reflected the facility included a step by step administration of IV medication.</p> <p>Record review of the facility training for nurses dated 09/26/24 and 09/27/24 revealed the nurses were trained with new skills check off which revealed process and steps from equipment and supplies gathering, maintaining infection control, assessment, steps in the procedure for IV medication administration, documentation and reporting.</p> <p>During interviews on 09/27/24 between 12:10 p.m. and 12:16 P.m., the MC and IP said the educator retrained them on IV medication administration from gathering supplies and equipment, medication verification, verification of resident, and maintaining infection control during medication administration. The MC and IP said the nurse should prep IV medication in the resident room on a clean field, then hang the medication bag on the pole, and the clamp and flow dial on the IV tubing should be closed before spiking the IV medication bag. The MC and IP said that after spiking the medication bag, you would open the flow dial, clamp, prime the tubing, make sure there was no bubble, and hang the tubing on the pole. The MC and IP said the nurse should prime the flush syringe before use; clean the port, flush the port; administered medication; and monitor the resident during medication administration. The MC and IP said after the nurse had administered the medication, the nurse would flush the resident's port with a primed flush syringe, and the resident would be monitored and documented.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/27/24 between 12:33 p.m. and 1:16 p.m., four nurses (2 RN and 2LVN) from day and night shifts were interviewed said the nurse should prep IV medication in the resident room on a clean field, then hang the medication bag on the pole, and close the clamp and flow dial on the IV tubing before spiking the IV medication bag. All nurses said that after spiking the medication bag, you would open the flow dial, the clamp, prime the tubing, make sure there was no bubble in the tubing. All of nurses said the nurse should prime the flush syringe before use; clean the port, flush the port; administered medication; and monitor the resident during medication administration. All nurses said after the nurse had administered the medication, the nurse would flush the resident's port with a primed flush syringe, and the resident would be monitored and documented.</p> <p>During an interview on 09/27/24 between 2:33 p.m. and 4:38 p.m., four nurses (2 RN and 2 LVN) from day and night shifts were interviewed said the nurse should prep IV medication in the resident room on a clean field, then hang the medication bag on the pole, and close the clamp and flow dial on the IV tubing before spiking the IV medication bag. All nurses said that after spiking the medication bag, you would open the flow dial, the clamp, prime the tubing, make sure there was no bubble in the tubing. All of nurses said the nurse should prime the flush syringe before use; clean the port, flush the port; administered medication; and monitor the resident during medication administration. All nurses said after the nurse had administered the medication, the nurse would flush the resident's port with a primed flush syringe, and the resident would be monitored and documented.</p> <p>During an interview on 09/27/24 at 3:02 p.m., the DON said she reviewed the facility policy on IV medication administration and created a new skills check-off list, which she used to train the nurses. The DON said the new skills check-off has processes and steps from equipment and supplies, assessment, steps in the procedure for IV medication administration, documentation, and reporting. The DON said she retrained the nurses. The DON said the facility had not placed the IV medication administration procedure error in QAPI, but the facility would discuss it when they have a QAPI meeting in 2 weeks, which is between October 8 and 9, 2024.</p> <p>During an observation on 09/27/24 at 7:50 p.m., LVN O administered IV medication to Resident #400 (Ceftriaxone 1 gm (50ML) infuse over 30 minutes at 100 ml/hour. LVN O gathered supplies from the medication room. LVN O cleaned the medication cart, placed a barrier, placed her medication and tubing, and syringes flush. LVN O sanitized her hands, donned her PPE, knocked on Resident #400's door, entered Resident #400's, introduced herself, and verified Resident #400 and medication. LVN O notified Resident #400 that she would administer his ABT for UTI. LVN O placed the pole beside Resident #400, seated in his wheelchair. The medication came mixed, and LVN O opened the IV tubing, closed off the flow dial and clamp, and spiked the medication bag. LVN O opened the flow dial and the clamp and primed the medication to flow through the tubing, three drops of medication were expelled from the tubing, and there was no bubble in the tubing. LVN O placed the tubing on the pole and primed the flush syringe. LVN O cleaned the port for 15 minutes and let the port air dry. LVN O flushed the port, administered the IV medication, and labeled the tubing. LVN O returned at 8:55 p.m. to Resident #40's room and checked the IV medication. There was still medication left in the tubing, about half of the tubing, and LVN O told Resident #400 that she would be back in a few minutes. LVN O returned to Resident #40's room and disconnected the IV tubing at 9:13 p.m. LVN O primed another flush syringe, flushed Resident #400's port, and capped it. LVN O assessed the IV site, and Resident #400 said he was fine.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/27/24 between 6:56 p.m. and 9:14 p.m., four nurses (2 RN and 2 LVN) from the night shift were interviewed said the nurse should prep IV medication in the resident room on a clean field, then hang the medication bag on the pole, and close the clamp and flow dial on the IV tubing before spiking the IV medication bag. All nurses said that after spiking the medication bag, you would open the flow dial, the clamp, prime the tubing, make sure there was no bubble in the tubing. All of nurses said the nurse should prime the flush syringe before use; clean the port, flush the port; administered medication; and monitor the resident during medication administration. All nurses said after the nurse had administered the medication, the nurse would flush the resident's port with a primed flush syringe, and the resident would be monitored and documented.</p> <p>On 09/27/24 at 9:40 p.m., the Administrator, the DON, the vice president were notified the Immediate Jeopardy was removed. However, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimum harm that is not immediate Jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36918</p> <p>Based on observation, interview, and record review, the facility failed to ensure licensed nurses are able to demonstrate competency in skills and techniques necessary to care for residents' needs for 1 of 1 residents (Resident #14) provided care by 1 of 1 staff (LVN A) reviewed for proficiency of license nurses.</p> <p>The facility failed to have a system in place to ensure the competency of nurses in Intravenous (IV) therapy techniques and failed to ensure LVN A demonstrated competency when he did not remove bubbles from the IV tubing, remove air from the syringe and flush the PICC line port before IV medication administration for Resident# 14.</p> <p>An IJ was identified on 09/26/24. The IJ template was provided to the facility on [DATE] at 5:59 p.m. While the IJ was removed on 09/27/24 at 9:40 p.m., with the Administrator, Senior [NAME] President, DON and [NAME] Present for Post - Acute Care. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated due to the facility need to evaluate the effectiveness of the corrected system.</p> <p>These failures could place Residents requiring Intravenous therapy at risk for serious harm, injury, and adverse effect from improper Intravenous (IV) therapy techniques.</p> <p>Findings include:</p> <p>Record review of Resident #14's face sheet dated 09/12/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses which included: diabetes mellitus (the body cannot control the amount of sugar in the blood), hypertension (pressure in the blood vessels is always higher than normal), and heart failure (when heart is unable to pump enough oxygenated blood to meet the body's needs).</p> <p>Record review of Resident #14's admission MDS assessment dated [DATE] revealed a BIMS score of 13 of 15 which indicated intact cognition. Further review revealed the resident needed moderate to extensive assistance with ADLs which required at least one staff assistance. Further review did not reflect Resident #14 was on IV medication.</p> <p>Record review of Resident #14's care plan initiated on 07/28/24 revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff. Further review reflected the resident was on IV antibiotic therapy related to infection osteomyelitis of the right toe. Intervention: administer medication as ordered.</p> <p>inability to perform activities of daily living independently. Intervention: Requires assistance of staff.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #14's clinical physician orders read in part . PICC/CENTRAL LINE (Peripherally Inserted Central Catheter): flush with 10 CC NS each shift before medication administration .order date 07/25/24 . meropenem intravenous solution reconstituted 500mg every 12 hours for osteomyelitis(bone infection ) for 2 weeks start date 09/04/24 .</p> <p>During an observation on 09/11/24 at 6:52 a.m., LVN A administered IV meropenem 500 mg intravenously to Resident #14, who was lying in bed on his back. LVN A went into the medication room, brought the medication and the tubing, and placed the medication at the nursing station. LVN A broke the medication seal, spiked the medication bag with the tubing, hung it on the IV pole, and cleaned Resident #14's port. After LVN A cleaned Resident #14's port, he opened the clamp, and the medication flowed into the tubing. There were bubbles in the tubing from a few inches below the chamber and at intervals throughout the tubing, and LVN A was about to connect the tubing to the port on Resident #14's arm when the surveyor intervened. LVN A said he was moving too fast and should have primed the medication and removed all the bubbles. Then LVN A primed the tubing and removed the bubbles. LVNA was about to connect the tubing to Resident #14's port without flushing the port, and the surveyor intervened. Then LVN A opened the flush and was about to flush Resident #14's port, but he did not remove the air in the flush. LVN A was about to insert the flush syringe into Resident #14 port when the surveyor intervened, and he primed the flush and administered the medication.</p> <p>During an interview on 09/11/24 at 3:54 p.m., LVN A said he did not realize the IV line had bubbles, and if he had administered the IV medication with bubbles, he could have caused Resident #14 to have an air embolism (bubbles trapped in a blood vessel that can block blood flow) . LVN A said he did not take out the air in the flush, and it was unsafe for Resident #14 because that would be air going through Resident #14's vein. LVN A said he had training in IV medication administration, and the DON and clinical manager monitored the nurses during rounding.</p> <p>During an interview on 09/12/24 at 11:55 a.m., The DON said LVN A should have ensured all the air was out of the tubing before he hooked up to Resident #14's port. The DON said LVN A should have primed the IV line to prevent air embolism and pain. The DON said LVN A should have flushed the port before administering the medication. The DON said the line should be flushed to make sure the line was patent (open and unobstructed free passage) and there was no clot or infiltration.</p> <p>During an interview on 09/26/24 at 2:55 p.m., LVN A said the facility provided in-services in the last month, and he did skills check-off, but the facility did not provide a certificate. LVN A said he never did a training that issued an IV administration certificate.</p> <p>During an interview on 09/26/24 at 3:27 p.m., the DON said that their contract pharmacy had done the nurse's IV Training. Still, the pharmacy representative told her he could not locate any training for facility nurses from 2021 to the present. The DON said RNs and LVNs should have an IV Administration Certificate before administering their first IV and be monitored during their first IV administration. The DON said she did not know if the IV Certificate was a requirement with the facility, State, or Board of Nursing, but she would look into it.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/26/24 at 3:53 p.m., NP said she did not get a call from the facility about LVN A attempted to administer IV medication with bubbles in the line or not flushing the line before administering the medication. NP said LVN A should have primed the tubing and made sure there were no bubbles in the line, but if the bubble was small, it might not cause any harm to Resident #14, but if the bubble was big(3mm), then the bubble could cause respiratory distress, air embolism. NP said LVN A should have pushed out the air from the flush syringe before he attempted to flush Resident #14's port, which was done to make sure the line was patent. The NP said 3mm of air could be bad for Resident #14.</p> <p>During an interview on 09/26/24 at 3:58 p.m., the Educator said IV certification was not required, but nurses are checked off on IV medication skills. The Educator said IV monitoring and staff rounding should be random and periodically by the CM and the DON. The Educator said if issues are observed, the facility will go back and look at where the nurse is having a hard time with skills, and the nurse would be retrained.</p> <p>During an interview on 09/26/24 at 4:59 p.m., the DON said the Educator and CM should randomly check the nurses for IV medication administration. The DON said since LVN A did not perform the IV medication administration as trained, the training was ineffective, and the Educator would re-educate LVN A.</p> <p>During an interview on 09/26/24 at 5:16 p.m., the Educator said the train was ineffective because LVN A did not demonstrate the competency needed for IV medication administration when he administered IV medication to Resident #14.</p> <p>During an interview on 09/27/24 at 10:59 a.m., the DON said the system breakdown happened when LVN A did not follow the correct procedure of IV medication administration because he did not lock the IV tubing before he spiked the IV medication bag. The DON said it caused the medication to flow fast, and bubbles formed in the tubing. The DON said LVN A should have primed the tube until he expelled the bubbles from the tube before he attempted to administer the medication to Resident #14.</p> <p>During an interview on 09/27/24 at 9:30 p.m., the Administrator and DON, the Administrator said there was a break when LVN A did not follow the proper procedure for IV medication. The Administrator stated LVN A was nervous, and LVN A goofed, which caused the error in the IV medication administration procedure.</p> <p>Record review of the facility medication and treatment order dated 12/15/24 read in part purpose . to ensure accurate, safe, and effective administration of prescribed medications . policy statement #21 . intravenous Orders: Will specify the type of solution, rate of flow, and volume to be infused .</p> <p>Record review of the facility IV medication administration policy dated 09/27/24 read in part . procedure #4 . prime new administration set, including add - on devices and tubing . #4b . remove cap from the tubing, open roller clamp to prime tubing, then hold the distal end of the tubing over sink, or trash can (keep the tip sterile) and allow all of the air bubbles to leave the tubing . #4c . ensure that no air bubble remain in tubing .</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the Texas board of nursing practice read . It is the opinion of the Board that the LVN shall not engage in IV therapy related to either peripheral or central venous catheters, including venipuncture, administration of IV fluids, and/or administration of IV push medications, until successful completion of a validation course that instructs the LVN in the knowledge and skills applicable to the LVN's IV therapy practice. The BON does not define or set qualifications for an IV Validation Course or for LVN IV certification. The LVN who chooses to engage in IV therapy must first have been instructed in the principles of IV therapy congruent with prevailing nursing practice standards .</p> <p>This was determined to be an Immediate jeopardy (IJ) on 09/26/24 at 5:59 p.m. The Administrator, Senior [NAME] President, DON and [NAME] Present for Post - Acute Care, was notified. The Administrator was provided with the IJ template on 09/26/24 at 5:59p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on 09/27/24 at 12:26p.m. a.m. PLAN OF REMOVAL</p> <p>[Facility]</p> <p>Medicare [number]</p> <p>Immediate Jeopardy Plan of Removal</p> <p>Annual Survey Completed: 09/11/2024</p> <p>Survey Reopened: 09/26/2024</p> <p>Notice of IJ: 09/26/2024</p> <p>F-726 Competent Nursing Staff</p> <p>Facility has implemented the following Plan confirming systems are in place to ensure that the nursing staff have and demonstrate competency skill sets necessary to safely administer intravenous (IV) medications including, but not limited to, checking for contraindications to ordered IV medication; confirming that the correct medication is selected with the appropriate concentration and dosage; practicing strict sterile technique when preparing and administering the IV medications; verifying correct IV equipment is used; completing hand hygiene; priming the IV tubing and ensuring there are no air bubbles in the line; inspecting the IV insertion site for signs of infection and infiltration; disinfecting the IV insertion site; flushing the IV site prior to connecting the tubing with the IV medication; administering medications at the prescribed rate to avoid complications; documenting correct information; and reporting. For further details, see No. 4 below.</p> <p>Immediate Action:</p> <p>Document here the action taken by the facility to ensure there are no residents in jeopardy or threat of harm. This could include assessing residents, reviewing records, assessing environmental concerns, providing training to immediate staff. Date each task and if needed when task will be completed and who is responsible for completing the task (if a contractor or supplies need to be coordinated what day the service or goods are available to the facility).</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>6. The facility initially undertook corrective action with regards to Resident #14. The facility confirmed that Resident #14 was discharged from the facility on September 24, 2024. At the time of the survey and after prompting by the surveyor, the involved LVN administering Resident 14's IV medications correctly primed the IV tubing, flushed the IV, and correctly administered the ordered IV medication.</p> <p>7. After being alerted by the surveyor to what happened, the Director of Nursing immediately performed just-in-time education on the appropriate procedure for administering IV medications with the involved LVN, who then successfully demonstrated the correct procedure to administer IV medications.</p> <p>8. The facility reviewed and revised its clinical guideline entitled Central Venous Access, Peripherally Inserted Central Catheters, Implanted Access Ports, and Peripheral Venous Access - Nursing Center to include more detail about the administration of IV medications. The facility also developed an IV Administration Checklist to include the step-by-step process for administration of IV medications. This updated process includes:</p> <p>Process: 1. Equipment and Supplies</p> <p>Steps</p> <p>1. Non-sterile gloves;</p> <p>2. Infusion administration sets (tubing and add-on devices);</p> <p>3. Add-on devices:</p> <ul style="list-style-type: none"> <li>o Catheter end cap, injection port;</li> <li>o Filters (if necessary);</li> <li>o Stopcock; and</li> <li>o Extension tubing.</li> </ul> <p>4. Infusate solution; and</p> <p>5. Alcohol pads.</p> <p>2. Assessment: Inspect intravenous catheter for any signs/symptoms of IV related complications at scheduled intervals. Observe equipment for sterility or problems.</p> <p>3. Steps in the Procedure: Perform Hand Hygiene</p> <p>Prepare equipment:</p> <ul style="list-style-type: none"> <li>a. Attach add-on devices to administration set;</li> <li>b. Clamp new administration tubing;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5.The rate of infusion. 6.The condition of the IV site. 7. Notification of the physician of any intravenous complications. 8.Resident's response to treatment. 9. The signature and title of the person recording the data.</p> <p>5. Reporting 1.Notify physician, supervisor and oncoming shift of Resident refusal of procedure or any complications.</p> <p>2. Report other information in accordance with facility policy and professional standards of practice.</p> <p>9. The facility is using the IV Administration Checklist to evaluate staff competency on IV medication administration.</p> <p>10. The Director of Nursing/Designee re-educated all nursing staff on the revised clinical guideline entitled Central Venous Access, Peripherally Inserted Central Catheters, Implanted Access Ports, and Peripheral Venous Access - Nursing Center to include the step-by-step process for the administration of IV medications.</p> <p>11. Utilizing the newly developed IV Administration Checklist, the Director of Nursing/Designee re-educated nursing staff on the process for administering IV medications as outlined in No. 3 above. No staff will be allowed to schedule shifts without first completing this re-education with demonstrated competency.</p> <p>12. All newly employed nursing staff will be educated on IV medication administration utilizing the Guideline and the newly developed IV Administration Checklist.</p> <p>13. Annually all nursing staff will undergo competency validation for IV medication administration.</p> <p>***The effectiveness of the re-education and the competency of the nursing staff will be measured by reviewing fallouts from the audits performed by the Director of Nursing/Designee and providing just-in-time re-education of the staff member responsible for the fallout. Also, for identified areas of non-compliance, staff members will be re-educated in mandatory staff meetings held monthly. Attendance at these meetings will be tracked.</p> <p>***All staff members will be educated on the process for IV medication administration described above before being allowed to work a shift.</p> <p>Completion Date: September 27, 2024</p> <p>Facility's Plan to Ensure Compliance Quickly:</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>How will the facility ensure compliance efficiently and timely? This could involve developing policies and procedures, training staff, repairing equipment, contacting physicians, having a QAIP meeting, developing forms, making repairs, or developing a new system. Be sure to document who provides the training, dates of training and how competency of staff of learning and training (return demonstrations, testing, competency checks). Please make sure dates of trainings are documented and if staff involvement is required that the staff member will not assume any job responsibilities until training has been received by them. Please make sure all audits, policies, notifications or services provided by outside contractors to remove the potential harm are dated.</p> <p>6. The Director of Nursing immediately performed just-in-time education on the appropriate procedure for administering IV medications with the involved LVN, who demonstrated competency in the procedure.</p> <p>7. The facility reviewed and revised its clinical guideline entitled Central Venous Access, Peripherally Inserted Central Catheters, Implanted Access Ports, and Peripheral Venous Access - Nursing Center to include more detail on the administration of IV medications.</p> <p>8. The facility developed a new IV Administration Checklist to evaluate staff competency on IV medication administration.</p> <p>9. The Director of Nursing/Designee re-educated all nursing staff on the revised clinical guideline entitled Central Venous Access, Peripherally Inserted Central Catheters, Implanted Access Ports, and Peripheral Venous Access - Nursing Center to include the step-by-step process for the administration of IV medications.</p> <p>10. Utilizing the newly developed IV Administration Checklist, the Director of Nursing/Designee re-educated nursing staff on the process for administering IV medications as outlined in No. 3 above. No staff will be allowed to schedule shifts without first completing this re-education with demonstrated competency.</p> <p>What program will be put into place to monitor the continued effectiveness of the system changes?</p> <p>4. There will be daily observation by the Clinical Educational Specialist/Nursing Manager/Designee of 100% of IV medication administrations for 30 days with 100% compliance.</p> <p>5. For days thirty-one (31) to ninety (90), the Clinical Educational Specialist/Nursing Manager/Designee will perform at random observations of IV medication administration weekly to confirm sustained compliance.</p> <p>6. During monthly QAPI Committee meetings, the IDT team will review the results of the observations/audits performed by the Clinical Educational Specialist/Nursing Manager/Designee and follow-up monthly to ensure adherence to policies/procedures. PIPs will be developed to address any areas of concern.</p> <p>Completion Date: September 27, 2024</p> <p>Responsible Person: Director of Nursing/Designee</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Surveyor monitored the plan of removal for effectiveness as follows:</p> <p>Record review of the facility just in time training revealed the DON did one on training for LVN A on 09/11/24 on IV medication administration and he returned demonstration.</p> <p>Record review of the facility policy on clinical guideline for central venous access peripherally inserted central catheter, implanted access port, and peripheral venous access reflected the facility included a step by step administration of IV medication.</p> <p>Record review of the facility training for nurses dated 09/26/24 and 09/27/24 revealed the nurses were trained with new skills check off which revealed process and steps from equipment and supplies gathering, maintaining infection control, assessment, steps in the procedure for IV medication administration, documentation and reporting.</p> <p>During interviews on 09/27/24 between 12:10 p.m. and 12:16 P.m., the MC and IP said the educator retrained them on IV medication administration from gathering supplies and equipment, medication verification, verification of resident, and maintaining infection control during medication administration. The MC and IP said the nurse should prep IV medication in the resident room on a clean field, then hang the medication bag on the pole, and the clamp and flow dial on the IV tubing should be closed before spiking the IV medication bag. The MC and IP said that after spiking the medication bag, you would open the flow dial, clamp, prime the tubing, make sure there was no bubble, and hang the tubing on the pole. The MC and IP said the nurse should prime the flush syringe before use; clean the port, flush the port; administered medication; and monitor the resident during medication administration. The MC and IP said after the nurse had administered the medication, the nurse would flush the resident's port with a primed flush syringe, and the resident would be monitored and documented.</p> <p>During an interview on 09/27/24 between 12:33 p.m. and 1:16 p.m., four nurses (2 RN and 2LVN) from day and night shifts were interviewed said the nurse should prep IV medication in the resident room on a clean field, then hang the medication bag on the pole, and close the clamp and flow dial on the IV tubing before spiking the IV medication bag. All nurses said that after spiking the medication bag, you would open the flow dial, the clamp, prime the tubing, make sure there was no bubble in the tubing. All of nurses said the nurse should prime the flush syringe before use; clean the port, flush the port; administered medication; and monitor the resident during medication administration. All nurses said after the nurse had administered the medication, the nurse would flush the resident's port with a primed flush syringe, and the resident would be monitored and documented.</p> <p>During an interview on 09/27/24 between 2:33 p.m. and 4:38 p.m., four nurses (2 RN and 2 LVN) from day and night shifts were interviewed said the nurse should prep IV medication in the resident room on a clean field, then hang the medication bag on the pole, and close the clamp and flow dial on the IV tubing before spiking the IV medication bag. All nurses said that after spiking the medication bag, you would open the flow dial, the clamp, prime the tubing, make sure there was no bubble in the tubing. All of nurses said the nurse should prime the flush syringe before use; clean the port, flush the port; administered medication; and monitor the resident during medication administration. All nurses said after the nurse had administered the medication, the nurse would flush the resident's port with a primed flush syringe, and the resident would be monitored and documented.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/27/24 at 3:02 p.m., the DON said she reviewed the facility policy on IV medication administration and created a new skills check-off list, which she used to train the nurses. The DON said the new skills check-off has processes and steps from equipment and supplies, assessment, steps in the procedure for IV medication administration, documentation, and reporting. The DON said she retrained the nurses. The DON said the facility had not placed the IV medication administration procedure error in QAPI, but the facility would discuss it when they have a QAPI meeting in 2 weeks, which is between October 8 and 9, 2024.</p> <p>During an observation on 09/27/24 at 7:50 p.m., LVN O administered IV medication to Resident #400 (Ceftriaxone 1 gm (50ML) infuse over 30 minutes at 100 ml/hour. LVN O gathered supplies from the medication room. LVN O cleaned the medication cart, placed a barrier, placed her medication and tubing, and syringes flush. LVN O sanitized her hands, donned her PPE, knocked on Resident #400's door, entered Resident #400's, introduced herself, and verified Resident #400 and medication. LVN O notified Resident #400 that she would administer his ABT for UTI. LVN O placed the pole beside Resident #400, seated in his wheelchair. The medication came mixed, and LVN O opened the IV tubing, closed off the flow dial and clamp, and spiked the medication bag. LVN O opened the flow dial and the clamp and primed the medication to flow through the tubing, three drops of medication were expelled from the tubing, and there was no bubble in the tubing. LVN O placed the tubing on the pole and primed the flush syringe. LVN O cleaned the port for 15 minutes and let the port air dry. LVN O flushed the port, administered the IV medication, and labeled the tubing. LVN O returned at 8:55 p.m. to Resident #40's room and checked the IV medication. There was still medication left in the tubing, about half of the tubing, and LVN O told Resident #400 that she would be back in a few minutes. LVN O returned to Resident #40's room and disconnected the IV tubing at 9:13 p.m. LVN O primed another flush syringe, flushed Resident #400's port, and capped it. LVN O assessed the IV site, and Resident #400 said he was fine.</p> <p>During an interview on 09/27/24 between 6:56 p.m. and 9:14 p.m., four nurses (2 RN and 2 LVN) from the night shift were interviewed said the nurse should prep IV medication in the resident room on a clean field, then hang the medication bag on the pole, and close the clamp and flow dial on the IV tubing before spiking the IV medication bag. All nurses said that after spiking the medication bag, you would open the flow dial, the clamp, prime the tubing, make sure there was no bubble in the tubing. All of nurses said the nurse should prime the flush syringe before use; clean the port, flush the port; administered medication; and monitor the resident during medication administration. All nurses said after the nurse had administered the medication, the nurse would flush the resident's port with a primed flush syringe, and the resident would be monitored and documented.</p> <p>Record review of the facility policy dated 09/26/24 read in part . procedure purpose . establish a facility - wide approach for assessing and maintaining staff competency in the provision of care and services . definitions . competency means the employee demonstrates the skills/procedure safely, correctly, effectively, legally, and has the capacity to complete the skill/procedure independently .</p> <p>On 09/27/24 at 9:40 p.m., the Administrator, the DON, the vice president were notified the Immediate Jeopardy was removed. However, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimum harm that is not immediate Jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36918</p> <p>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 of each resident, for 1 ( Resident #1) of 7 residents and 2 (1A and 2 B medication cart) out of 4 [NAME] on carts reviewed for pharmacy services.</p> <p>The facility failed to ensure LVN A did not crush enteric coated aspirin during oral medication administration for Resident# 1.</p> <p>The facility failed to ensure station 1A medication cart did not contain three residents (Resident #114 midodrine 5 mg, Resident #6 dexamethasone 40mg, Resident #159 ondansetron 40mg) discontinued medications.</p> <p>The facility failed to ensure station 2B medication cart did not have 2 opened eyes drops which had expired, and one discontinued medication.</p> <p>These deficient practices could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication.</p> <p>Findings include:</p> <p>1. Record review of Resident #1's face sheet dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had diagnoses which included: stroke (loss of blood flow to part of the brain which damages brain tissue), traumatic brain dysfunction (brain injury caused by an external force such as a blow), and traumatic spinal dysfunction (permanent spinal cord damaged by physical trauma).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed on section C700 Resident #1 had memory problems. Further review revealed the resident needed extensive to dependent assistance with ADLs which required at least one staff assistance.</p> <p>Record review of Resident #1's care plan initiated on [DATE] revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff.</p> <p>Record review of Resident #1's order listing report read in part . Aspirin Tablet Chewable Give 81 mg by time a day for DVT Prophylaxis patient is bed bound .</p> <p>Record review of Resident #1's MAR dated for [DATE] read in part . Aspirin Tablet Chewable Give 81 mg by mouth one time a day for DVT(blood cloth within a vein in the leg) Prophylaxis(prevent disease) patient is bed bound -Start Date- [DATE] .</p> <p>During an observation on [DATE] at 7:13 a.m., LVN A was about to crush 81 mg of enteric-coated aspirin when the surveyor intervened.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  University Place Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7480 Beechnut Houston, TX 77074	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 3:54 p.m., LVN A said he was about to crush the enteric aspirin when the survey stopped him. LVN A said the medication was a delayed release, and Resident #1 would not get the right dose of the medication at the right time if he had crushed the medicine. LVN A said the DON and clinical manager monitored the nurses when they made Radom rounds. LVN A said he had training in medication administration.</p> <p>During an interview on [DATE] at 12:18 p.m., the DON said LVN A should not crush enteric-coated aspirin because it should be swallowed whole to protect Resident #1's stomach because of ulcer and bleeding, and she thought it would not do any harm to Resident #1, but enteric-coated aspirin should not be crushed.</p> <p>2. During an observation of station 1A nurse cart and interview on [DATE] at 9:35 a.m., revealed the following discontinued medications:</p> <p>*Midodrine 5 mg-Resident #300</p> <p>*Dexamethasone 40mg- Resident #6</p> <p>*Ondansetron 40mg- Resident #159</p> <p>RN A said she usually did not work from station 1A nurse cart. RN A said those medications were for Resident #114, Resident #159, and Resident #6, and they brought them from home. RN A said the facility did not use the medications the resident brought from home. RN A said nurses should put home medication in a zip lock bag and place it in the medication room, and the discharged nurse would give the medicines back to the residents during discharge. RN A said the nurse could have given the home medication in error if the nurse had left the medicines in the medication cart.</p> <p>During an interview on [DATE] at 12:43 p.m., the DON said if any resident brought medication to the facility, the nurses should put the medication in a zip-loc bag and place the medication in the medication room, and if it was a controlled medication, it should be locked up but not in the medication cart. The DON said home medications should not be in the cart because it could cause conflict; the dose from home could be different from the facility dose.</p> <p>3. During an observation of section 2 B's nurse cart on [DATE] at 10:27 a.m., revealed two opened eye drop bottles, and the open date was [DATE]. There was a discontinued medication(dexamethasone 40 mg) in the cart, too.</p> <p>During an interview on [DATE] at 4:03 p.m., LVN A said the nurses should remove discontinued medications immediately and lock in the medication slot box in the medication room. LVN A said discontinued medication should be removed from the cart immediately to prevent medication errors. LVN A said the nurse was responsible for taking discontinued medication from the cart by the nurse who was on duty when the medication was discontinued. LVN A said he was trained on medication storage and discontinuing medication, and the clinical director mentors the nurses when he makes rounds. LVN A said the pharmacy and pharmacy tech checked the cart for discontinued and expired medication in the cart.</p> <p>During an interview on [DATE] at 4:10 p.m., LVN A said the two eye drops that were open and dated had expired, and the expiration date for the eye drops was 28 days to 30 days after opening. LVN A said if the resident was administered expired medication, it could cause more harm to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 12:27 p.m., the DON said the opened eye drops container should be disposed of 28 days after opening. The DON said the pharmacy technician checks the cart three times a week for expired medication. The DON said the expired medicines would not be effective if they were administered to the resident.</p> <p>During an interview on [DATE] at 12:41 p.m., The DON said the nurses should store discontinued medication in a locked compartment in the medication room. The DON said the nurses should immediately remove discontinued medications from the cart to prevent discrepancies.</p> <p>Record review of the facility medication and treatment order dated [DATE] read in part purpose . to ensure accurate, safe, and effective administration of prescribed medications .</p> <p>Record review of the facility crushed medications dated [DATE] read in part . purpose . medications shall be crushed only when it was appropriate and safe to do so, consistent with physician orders .</p> <p>Record review of the facility policy on medication labeling and storage dated [DATE] read in part . medication storage #3 . If the facility has discontinued, outdated or deteriorated medications or biologicals, it is quarantined for return or destruction of these items.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36918</p> <p>Based on observation, record review, and interview, the facility failed to ensure that drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles for 3 (station 1A, station 2A and station 2B) of 4 medication carts reviewed for medications storage.</p> <ul style="list-style-type: none"> <li>- LVN A left Station 2 A and station 2B medication carts unlocked on the hallway.</li> <li>- MA F left two medication containers on top of station 1A medication cart and went into a resident's room during medication administration.</li> <li>- MA F left station 1A medication cart unlocked on the hallway.</li> </ul> <p>These failures could affect residents, placing them at risk for ingesting unprescribed medication and hospitalization .</p> <p>The findings include:</p> <p>During an observation on 09/11/24 at 6:50 a.m., LVN A left the station 2A medication cart unlocked in front of room [ROOM NUMBER] and went to room [ROOM NUMBER]. LVN A returned to the medication cart, took medication from the cart, went into the resident's room, and administered medication while the cart was unlocked.</p> <p>During an observation on 09/11/24 at 6:58 a.m., LVN A left station 2 B's medication cart unlocked, went to the medication room, went into room [ROOM NUMBER], and administered medication to Resident #14.</p> <p>During an interview on 09/11/24 at 3:54 p.m., LVN A said he forgot to lock the station 2A medication cart and went into room [ROOM NUMBER]. LVN A said he did not lock the medication cart when he went to the medication room. LVN A said anybody could have gotten into the cart and taken any medication. LVN A said it was a safety issue because a resident could have taken medicines in his cart. LVN A said he also left station 2 B's medication cart unlocked when he went to room [ROOM NUMBER].</p> <p>During an observation on 09/11/24 at 8:15 a.m., MA F left the station 1A cart unlocked in the hallway, went into a resident's room, and administered medication to the resident.</p> <p>During an interview on 09/11/24 at 5:31 p.m., MA F said station 1 A's medication cart should always be locked when it was not in use, or the medication aide was out of sight. MA F said if the cart was not locked, then staff or residents could get into the cart and take medication, and if the resident took the medication the resident was not supposed to take, it could harm the resident.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/12/24 at 12:23 p.m., the DON said MA F and LVN A should not have left the medication carts unlocked when not in use for safety to prevent anybody from getting into the cart and taking any medication.</p> <p>During an observation on 09/11/24 at 8:01 a.m., MA F left two bottles of medications on top of station 1A medication cart in the hallway and entered a resident's room.</p> <p>During an interview on 09/11/24 at 5:12 p.m., MA F said she left two medications on top of the medication cart. MA F said leaving medicines on top of the medication cart was not the appropriate thing to do when she was away from the cart because another resident could get into the medication cart, and if the resident had taken the medication, it could cause harm to the resident.</p> <p>During an interview on 09/12/24 at 12:25 p.m., the DON said MA F should not have left medications on top of the cart because it was a safety issue and it would be a medication error, and if any resident took the medication, the resident could have adverse effects.</p> <p>Record review of the facility policy on medication labeling and storage dated 09/12/24 read in part . purpose . the facility stores all medications and biologicals in locked compartments . #4 . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36918</p> <p>Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to prevent the development and transmission of infection for 2 of 6 staff (RN A, LVN A,) observed for infection control.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure RN A followed proper infection control and PPE procedure during ACCU - check(blood sugar check) for Resident #110.</li> <li>The facility failed to ensure LVN A followed proper infection control and PPE procedure during IV medication administration for Resident #14.</li> <li>The facility failed to ensure RN A followed proper infection control and PPE procedure during subcutaneous medication administration for Resident #113.</li> </ol> <p>These failures could place the residents at risk for infection.</p> <ol style="list-style-type: none"> <li> <p>Record review of Resident #110's face sheet dated 09/12/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #110 had diagnoses which included: closed fracture of two ribs (a break ribs where the skin remains intact).</p> <p>Record review of Resident #110's order listing report for September 2024 read in part .ACCU Checks before meals for DM2 Other active date 08/17/2024 .</p> <p>An observation on 09/12/24 at 6:32 a.m. revealed RN A removed the gloves, which she wore while she checked Resident #110's blood sugar, which had blood spots, donned another pair of gloves, and sanitized the glucometer. RN A did not sanitize or wash her hands after she checked Resident #110's blood sugar.</p> <p>During an interview on 09/11/24 at 4:44 p.m., RN A said she was supposed to sanitize her hands after she removed the dirty gloves, which she wore when she checked Resident #110's blood sugar. Then, she would have donned another glove, but she did not; it was an infection control issue.</p> <p>During an interview on 09/11/24 at 12:11 p.m., the DON said RN A should have sanitized her hands when she changed the dirty gloves after she checked Resident #110's blood sugar before she donned the clean gloves and wiped down the glucometer because it was an infection control issue.</p> </li> <li> <p>Record review of Resident #14's face sheet dated 09/12/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses which included: diabetes mellitus (the body cannot control the amount of sugar in the blood), hypertension (pressure in the blood vessels is always higher than normal), and heart failure (when heart is unable to pump enough oxygenated blood to meet the body's needs).</p> <p>(continued on next page)</p> </li> </ol>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #14's admission MDS assessment dated [DATE] revealed a BIMS score of 13 of 15 which indicated intact cognition. Further review revealed the resident needed moderate to extensive assistance with ADL's which required at least one staff assistance.</p> <p>Record review of Resident #14's care plan initiated on 07/28/24 revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff.</p> <p>Record review of Resident #14's clinical physician orders read in part . PICC/CENTRAL LINE: flush with 10 CC NS each shift before medication administration .order date 07/25/24 . meropenem intravenous solution reconstituted 500mg every 12 hours for osteomyelitis for 2 weeks start date 09/04/24 .</p> <p>During an observation on 09/11/24 at 6:52 a.m., LVN A administered IV meropenem 500 mg intravenously to Resident #14. LVN A went into the medication room and brought out the medication and the tubing and placed the medication at the nursing station. LVN A went to the medication cart, wrote the date on a sticker, and returned it to the nursing station counter. LVN A opened the plastic, which had the IV tubing, and placed the tubing on the counter that was not disinfected or had any barrier. LVN A went into Resident #14's room, was in the enhanced barrier precautions room because the sign on the door, and he did not don a gown and placed the medication on top of Resident #14's nightstand. The nightstand had Resident #1's personal care items (lotion, a cup, and paper towels). LVN A did not disinfect or place any barrier on the nightstand. LVN A was touching the outer uniform pockets, and he went into both uniform pockets with his gloved hands and said he was looking for his watch so he could write what time he started the IV. LVN A used the same gloves he touched his pocket for the entire care.</p> <p>During an interview on 09/11/24 at 3:42 p.m., LVN A said Resident #14 had a PICC line, and he should have followed enhanced infection control. LVN A said he placed the medication and tubing on the nursing station counter and wrote the date on the label. LVN A said he opened the tubing and placed the label on the tubing. LVN A said he should have prepped for the IV medication administration on a clean field to prevent cross-contamination. LVN A said he should not have placed the medication on the countertop or on top of Resident #14's nightstand because it was cross-contamination. LVN A said he should not have touched or put his gloved hands in the uniform pocket and continued administering medication to Resident #14 because of infection control, which he could have transferred his germs to the resident. LVN A said he should have donned the disposable gown because Resident #14 was on enhanced precaution. LVN A said he had in service on infection control, PPE, and hand washing, and the IP monitored nurses during rounding.</p> <p>During an interview on 09/12/24 at 12:02 p.m., the DON said LVN A should have donned the PPE when he went to provide care for Resident #14 in enhanced barrier isolation. The DON said the setup for IV medication should be a clean procedure and set up in the medication room or bedside. The DON said LVN A should have disinfected the nightstand before she placed the medication and opened the IV tubing on the nightstand to prevent cross-contamination.</p> <p>3.</p> <p>Record review of Resident #113's face sheet dated 09/12/24 revealed he was an [AGE] year-old female admitted to the facility on [DATE]. Resident #113 had diagnoses which included: closed right fracture of right femur (a break in the thigh bone where the skin remains intact).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #113's order listing report for September 2024 read in part .Heparin Sodium (Porcine) Solution 5000 UNIT/ML Pharmacy Inject 5000 unit subcutaneously every 12 hours for clotting prevention active date 09/08/2024 .</p> <p>During an Observation on 09/11/24 at 7:45 a.m., RN A sanitized her hands and knocked on Resident #113's door, then, she opened the door and placed the medication on Resident #113's bedside table. RN A went into the gloves box in the room by the entrance door and took gloves from the box. RN A donned gloves on her right hand, closed Resident #113's door with her left hand, and then donned the gloves on her left hand. RN A did not wash or sanitize her hands before she donned the gloves and provided a subcutaneous injection (injection under the fatty tissue) for Resident #113.</p> <p>During an interview on 9/11/24 at 5:00 p.m., RN A said she forgot to sanitize her hands before she donned the gloves when she entered Resident #113's room and administered Heparin Sodium (Porcine) Solution subcutaneously to Resident #113 and it was cross-contamination. RN A said she had in-service on infection control and the IP monitored nurses when she rounded. RN A said Resident #113 could get sick or even sent back to the hospital.</p> <p>During an interview on 09/11/24 at 12:16 p.m., the DON said RN A should have sanitized her hands before administering the Heparin Sodium (Porcine) Solution to Resident #113. The DON said it was an infection control issue because once RN A entered Resident #113's room, she should have washed or sanitized her hands.</p> <p>Record review of the facility policy on hand hygiene dated 5/27/24 read in part . purpose . Effective hand hygiene removes transient microorganisms, dirt, and organic material from the hands and decreases the risk of cross contamination to patients, patient care equipment and the environment . policy statement . HCWs will perform hand hygiene following the guide for hand hygiene product use when:</p> <ul style="list-style-type: none"> <li>a. Entering and exiting patients' rooms. (This will be the measure of hand hygiene compliance.)</li> <li>b. Before donning sterile or non-sterile gloves</li> <li>c. Before performing invasive procedures or handling an invasive device.</li> <li>d. Before handling medications.</li> <li>f. After contact with body fluid or excretions, mucus membranes, non-intact skin or wound dressings whether or not gloves were worn.</li> <li>g. If moving from a contaminated body site to another body site during the care of the same patient.</li> <li>h. After contact with inanimate surfaces and objects in the patient room/care area.</li> <li>i. After removing sterile or non-sterile gloves.</li> </ul> <p>Record review of the facility isolation policy dated 11/16/21 read in part . statement #2. The use of transmission-based precaution is to prevent the spread of certain infectious agents, which required additional precautions beyond standard precautions .</p> <p>(continued on next page)</p>		

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