

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Tomball Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 815 N Peach St Tomball, TX 77375	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44591</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 of 1 resident (Resident #51) reviewed for gastrostomy tube management.</p> <p>- The facility failed to ensure LVN D mixed crush medications with water as ordered by MD to Resident #51 by pouring dry powder medication into the resident's G-tube.</p> <p>This failure could place residents at risk for adverse effects, pain, discomfort and not receiving the therapeutic effects of the medication.</p> <p>Findings included:</p> <p>Record review of Resident #51's Face Sheet dated 07/24/2024 revealed [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included: difficulty swallowing, dementia, gastrostomy status (a gastrostomy feeding tube (G-tube) insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach.).</p> <p>Record review of Resident #51's MDS dated [DATE] revealed the resident had severely impaired cognition as indicated by a BIMS score of 00 out of 15, and used of a feeding tube while a resident.</p> <p>Record review of Resident #51's undated Care Plan revealed, focus- requires tube feeding related to difficulty swallowing; intervention: administer tube feeding and water flushes as ordered, check for placement and gastric contents/residual per facility protocol.</p> <p>Record review of Resident #51's MD Order revealed the following active orders: Every shift flush enteral tube with 30 milliliters of water dash post medication administration and 5 to 10 milliliters water between each medication. Every shift for peg tube crushed medication contents of open capsule as well as liquid medications are diluted with at least five meals of water when fluid is not restricted. May crush crushable meds, open caps and mix with palatable substance.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observed on 11/6/24 at 7:52 am LVN D preparing medication for administration to Resident #51. She retrieved Norvasc 10 mg, Tylenol 650 mg, Lorazepam 0.5 mg, Carvedilol 6.25mg, Losartan 25 mg, Metformin 500mg, Lexapro 5 mg, Prilosec 20 mg and Xarelto 20 mg. Medications that were in dry, powder form were returned to the medication cup and LVN D entered into the resident's room. After repositioning the resident, LVN D retrieved 2 cups of room temperature water (each cup containing about 6-8 ounces) from Resident #51's bathroom and then checked the resident for placement and residual feeding. At 08:24 AM, LVN D flushed Resident #51's G-tube with a syringe containing 30 ml of water. She then poured undissolved powder medication down Resident # 51's G-tube followed by 5-30 ml of water. The method was continued for 6 more medications until the syringe became clogged on the seventh medication. LVN D unclogged the syringe and continued to place undissolved powder medication into the syringe followed by water for the remaining 2 medications. She the flushed the G-tube with 30 ml of water and reconnected the enteral feeding.</p> <p>Interviewed LVN D on 11/6/24 at 8:36 am regarding the process of giving undissolved powder medication into the G-tube and she stated she had learned to place undissolved powder medication into the syringe followed by water here and there.</p> <p>Interviewed LVN E on 11/6/24 at 10:05 am regarding administration of medications with residents with a G-tube. LVN E verbalized the policy regarding placing water with undissolved powder medication, mixing together and after administration, following with 10-15 milliliters water to flush between medications. LVN E stated undissolved powder medication placed directly into syringe was not done because it may cause blockage in the syringe during medication administration. LVN E reported he had a recent in-service by the facility regarding G-tube medication administration within the last 60 days.</p> <p>Interviewed LVN D on 11/6/24 at 10:06 am, LVN D reported going forward she would mix undissolved powder medication with water prior to administration. LVN D stated she was in-serviced by the facility within the last 60 days regarding G-tube medication administration.</p> <p>Interviewed the DON on 11/6/24 at 1:55 pm, the DON verbalized the facility procedure for administering medications into a G-tube. The DON said prior to administering medication via G-tube, nurses must dissolve the medications in 5-10 mL and LVN D should not have poured powdered/crushed medications directly into the Resident #51's tube because it could clog the tube. The DON stated medications were to be crushed, mixed with water and followed with 5-10 ml water between medications. When asked should undissolved powder medication be placed into the syringe and followed with 5-30 milliliters of water, the DON stated she had never heard of that. The DON reported risks to the resident if not mixing undissolved powder medication in water and followed with 10-15 milliliters water could clog the G-tube or syringe.</p> <p>Interviewed the Administrator on 11/7/24 at 2:40 pm regarding expectation for nursing staff and nursing tasks. The Administrator stated he expected his nurses to follow doctors' orders and facility policy and procedures for all tasks. The DON was responsible for nursing staff competencies and all nursing managers were expected to assure proper nursing care. When there was a failure with nursing care, such as not following doctors' orders or facility policy and procedures the Administrator expected the DON and nursing managers to educate and monitor nursing staff until proficient.</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 - Few</p>	<p>Record review of the facility policy titled Medication Administration Enteral Tube Feeding issued 02/02/2015 and reviewed 02/10/2020 revealed 8. Crushed medication, contents of opened capsules, as well as liquid medications are diluted with at least 5 ml of water when fluid is not restricted. 11. Enteral tube must be flushed with at least 10 to 15 ml of water between each medication, unless otherwise ordered by prescriber.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41469</p> <p>Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in one of one kitchen reviewed for dietary services.</p> <ol style="list-style-type: none"> The facility failed to ensure foods were not stored past their use by date. The facility failed to ensure all food and drinks in storage were labeled. The facility failed to ensure the dishwasher was maintained and effectively sanitizing dishware. <p>These failures could place residents at risk of foodborne illness.</p> <p>Findings included:</p> <p>Observation of the kitchen on 11/05/2024 at 9:10AM revealed the following:</p> <p>- Fridge #1 contained a bin of mandarin oranges, dated 10/23/2024 and butterscotch pudding, date 10/18/2024, and a tray of individually poured drinks without a label.</p> <p>In an interview with the Dietary Manager on 11/05/2024 at 9:15AM, she stated she did not know for how long the leftover pudding and mandarin oranges were to stay in storage before throwing them away. She also said the drinks were supposed to be labeled and it may have been stored without a label by the dietary staff that was in training.</p> <p>Observations of the low-temp dish machine on 11/05/2024 at 9:30AM, and interview with the Dietary Manager and Dietary Aide A revealed dishes were being washed by Dietary aide A while the wash cycle was running at 98 F and the rinse cycle was running at 104 F. The Dietary Manager was then observed to ask Dietary aide A to document temperatures on the dishwasher temperature log. Dietary Aide A then wrote 100 for the wash cycle and 120 F for the rinse cycle. When asked how she knew what the temperatures were for the dishwasher, she stated she dipped the test strips in the dish machine water to check the temperature. She then grabbed the water sanitation test strips to show the surveyor the ppm was ranging from 50-100 ppm. When asked where the temperature gauge was on the dish machine, she stated she did not understand. The Dietary Manager then came forward to show Dietary Aide A where the temperature gauge was and stated it looked like the temp was at about 118-120 F. The Surveyor at this time checked the temperature gauge and rebutted that the temperature gauge was actually reading 110 F, to which the Dietary Manager agreed. The Dietary Manager said water temperatures ranging from 110 F to 120 F was appropriate for operating the dish machine.</p> <p>(continued on next page)</p>

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