STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675764	A. Building B. Wing	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Branch Transitional Care Center	1615 Hillendahl Rd Houston, TX 77055

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observations, interviews, and record review the facility failed to ensure residents who were incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections and restore as much bowel functions as possible for 1 of 5 (Resident #1) residents reviewed for bowel and blader incontinence. -CNA A failed to change Resident #1's soiled brief every 2 hours. -CNA A failed to thoroughly clean resident's vaginal area to prevent infections. This failure placed resident at risk for unwanted UTI's and a decrease in quality of life. Findings were: Record review of Resident #1's face sheet dated 03/08/2024 revealed that resident was an 56-year- old female admitted to the facility originally on 02/23/20218 and latest return to the facility on [DATE] with the diagnoses that included the following: dementia (impairment of at least two brain functions that include memory loss and judgement), anxiety, type 2 diabetes mellitus, hypertensive (high blood pressure) heart disease, obesity, chronic obstructive pulmonary disease (group of lung diseases that block airflow making it difficult to breathe), diarrhea, depression, bipolar disorder (mood swings ranging from depression to high energy and excitement), and personal history of urinary tract infections. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed that the resident's BIMS score was 14 indicating that resident cognition was intact. Further review of MDS section GG revealed that the resident was dependent for personal hygiene. Further review revealed that the resident was always incontinent of bowel and bladder. Record review of Resident #1's diagnostic testing dated 09/19/2023 revealed a urine C & S reflected that the resident had tested positive for UTI positive for the following bacteria in the urine klebsiella pneumoniae and Escherichia coli. Record review of Resident #1's Physician orders for the month of September 2023 reflected the following order: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dated 09/23/2023 Levaquin (antibiotic) 500mg po q day times 7 days dx UTI. -Dated 09/26/2023 Nystatin (used to treat fungal or yeast infections on the skin) powder topical to buttocks DX: rash. Record review of Resident #1's MAR & TAR for the month of September 2023 revealed that the facility was following physician orders. Record review of Resident #1's care plan dated 08/11/2019 and edited on 01/31/2024 revealed that the resident was being care planned for being incontinent of bowel and bladder. The resident has a history of potential for UTI's. The interventions included the following: check on resident at routine intervals to assess needs and offer with toileting tasks. The resident [NAME] dependent for toileting tasks/ incontinent care. Ensure cloths and linens [NAME] clean, and dry; change PRN. Provide incontinent care promptly when found wet or soiled. Observation on 03/08/2024 at 8:45AM revealed Resident #1 was resting in bed. Further observation was made of resident fitted sheet with a circle stain outer edges were brown in color. In an interview on 03/08/2024 at 8:45AM Resident #1 said her brief needed to be changed. Resident said her brief had not been changed since the night shift. Resident said she had asked CNA A to change her brief earlier in the morning. The CNA told telling her that she would change her brief but never came back. Resident #1 began to cry. Observation on 03/08/2024 at 9:50AM of incontinent care revealed CNA A entering Resident #1's room with clean linen in hand along with CNA B. CNA A and CNA B went to the bathroom to wash their hands and put on a set of clean gloves. Further observation was made of the resident brief being heavily soiled with urine and feces. CNA A did not spread resident labia (folds of skin around the vaginal opening) apart to clean the resident's vaginal area thoroughly leaving feces in the resident's vaginal area. Further observation was made of the resident having redness to her buttocks area. In an interview on 03/08/2024 at 10:27AM CNA A said she worked the 6AM-2PM full time. CNA A said this was the first time she had provided incontinent care for Resident #1 for the morning. CNA A said the unit was supposed to have 3 CNAs, but one CNA did not come to work. CNA A said therefore, there were only 2 CNAs working on the unit. CNA A said she was supposed to provide incontinent care to the residents at least every 2 hours. CNA A said when the residents briefs, were not changed in a timely manner, it placed the residents at risk for infections, particularly UTI's and skin breakdown . In an interview on 03/08/2024 at 10:40AM LVN C said if a CNA was unable to come to work, she did not have any problem assisting the CNAs with direct resident care if they asked . In an interview on 03/08/2024 at 10:43AM the Unit Manager said the number of residents on the unit was 40. The Unit Manager said one CNA had called off leaving the unit with 1 nurse, 2 CNA's, a medications aide who was a CNA, hospitality aide, and herself. The Unit Manager said she helped the floor staff wherever they needed help. The Unit Manager said she was not aware that CNA A needed help. The Unit Manager said the CNAs should be making rounds on the residents every 30 minutes and providing incontinent care every hour and between meals . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/08/2024 at 11:15AM the DON said the CNAs should be checking the residents for incontinent care at a minimum of every 2 hours and as needed. The DON said he was aware that a CNA had called off on Unit 3, but the unit had the following staff available: 1 LVN, a Unit Manager who was also an LVN, a CMA who was also a CNA, 2 CNAs, a hospitality aide, a staffing Coordinator who was also a CNA that was assisting with the care of the residents. The DON said the hospitality aide provided the residents with hydration and assisted with feedings. Record review of the facility policy on Perineal Care revised October 2010 revealed in part: . Purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition .Female residents separate the labia and wash downward from front to back .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #1) of 5 residents reviewed for infection control. -CNA A failed to change gloves and sanitize her hands to place clean fitted sheet on Resident #1's mattress during incontinent care. -CNA B took a bedside table from another resident room to Resident #1's room to use during care . -CNA B placed soiled linen bag on floor. This failure placed resident at risk for cross contamination, risk of infections, and decrease in health. Findings were: Record review of Resident #1's face sheet dated 03/08/2024 revealed that resident was an 56year old female admitted to the facility originally on 02/23/20218 and latest return to the facility on [DATE] with the diagnoses that included the following: dementia (impairment of at least two brain functions that include memory loss and judgement), anxiety, type 2 diabetes mellitus, hypertensive (high blood pressure) heart disease, obesity, chronic obstructive pulmonary disease (group of lung diseases that block airflow making it difficult to breathe), diarrhea, depression, bipolar disorder (mood swings ranging from depression to high energy and excitement), and personal history of urinary tract infections. Record review of Resident #1's quarterly MDS dated [DATE] revealed that resident BIMS score was 14 indicating that resident cognition was intact. Further review of MDS section GG revealed that resident was dependent for personal hygiene. Further review revealed that resident was always incontinent of bowel and bladder. Observation on 03/08/2024 at 8:45AM revealed Resident #1 was resting in bed. Further observation was made of resident fitted sheet with brown ring around the soiled circled edge. In an interview on 03/08/2024 at 8:45AM Resident #1 said her brief needed to be changed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/08/2024 at 9:50AM revealed CNA A entered Resident #1's room with clean linens in hand along with CNA B. CNA A went to the bathroom to wash her hands and put on a set of clean gloves. Further observation was made of CNA B leaving Resident #1's room and returning to Resident #1's room with a bedside table that was unclean with stains on surface. CNA B went and washed her hands but did not sanitize the bedside table proceeding to place on a clean set of gloves to assist CNA A with incontinent care for Resident #1. CNA A placed a clean brief along with other personal care items on the bedside table. Further observation was made of the resident brief being heavily soiled with urine and feces. When CNA A positioned resident to her left side to finish cleaning feces off resident buttocks,. CNA A proceeded to apply a clean fitted sheet without changing gloves, sanitizing her hands, and placing on a new set of gloves. CNA B placed the soiled materials that were inside of a bag on the floor . In an interview on 03/08/2024 at 10:10AM CNA B said she did not sanitize the bedside table that she had taken from another resident's room to provide care for Resident #1 because too much was going on and therefore did not take the time to do so. CNA B said she did not know that it was wrong to place soiled linens inside of a bag on the floor. CNA B said she could not remember the last time she had received an in-service on infection control. CNA B said she had been working at the facility for approximately 2.5 months. In an interview on 03/08/2024 at 10:27AM CNA A said soiled linens inside of a bag should not be placed on the floor for infection control purposes and cross contamination. CNA A said staff should not be using other residents' bedside tables due to cross contamination. CNA A said the reason she did not change her soiled gloves before applying clean sheets to Resident #1's mattress was due to her getting nervous during incontinent care . In an interview on 03/08/2024 at 11:15AM the DON said the staff should not be taking equipment out of other resident's rooms or placing bags with soiled material inside of it on the floor for infection control and cross contamination . In an interview on 03/08/2024 at 11:35AM the infection control nurse said the staff had received infection control training that included handwashing on 03/01/2024. The infection control nurse said she had done more training on infection control on 03/6/2024. The infection control nurse said CNA A was present but later found out that CNA B was not present. The infection control nurse said she had asked CNA B why she did not attend, and CNA B said she was working on the unit at the time of the mandatory training and was unable to come to the training. The infection control nurse said all staff received training on infection control at the time of hire and annually. The infection control nurse said staff were not supposed to share resident to resident bedside tables or place soiled linen bags on the floor due to cross contamination. Record review of the facility last in-service on infection control mandatory was 03/06/2024. Further review revealed that CNA A had signed that she received the in-service, but CNA B had not. Record review of the facility policy on Infection Control dated 11/28/2017 revealed in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The facility shall investigate, control and/or prevent infections through implementation of an Infection Prevention & Control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Employees are required to use appropriate hand-washing after each direct resident contact when hand-washing is indicated by accepted professional practice .Linens are properly handled, stored, processed, and transported to prevent the spread of infection .