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	04/19/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect for two (Resident #54 and Resident #148) of seven residents reviewed for dignity. The facility failed to ensure Resident #54, and Resident #148 were dressed in their own clothes. This failure could place residents in the facility at risk of feeling uncomfortable and disrespected. Findings included: Record review of Resident #54's face sheet dated 04/19/24 revealed a [AGE] year-old female was admitted to the facility on [DATE]. Resident #54 had diagnoses which included: Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), dementia (impair ability to remember, think, or make decisions that interferes with doing everyday activities) and hypertensive heart disease (all direct and indirect sequelae of chronic high blood pressure). Record review of Resident #54's quarterly MDS assessment, dated 03/06/24 revealed: Resident #54 had 99 entered for BIMS because Resident # 54 was not able to complete the interview. Resident #54's functional status revealed she was maximal assistance from staff with bed mobility, transfer, grooming and toilet use. Record review of Resident #54's care plan initiated 09/04/20 revealed the resident required assistance for ADL and mobility tasks due to weakness, impaired balance, poor endurance, and activity intolerance. Intervention: requires maximum assistance from staff for dressing and clothing changes daily, and PRN. Assist resident with shower three times per week per schedule and PRN. Resident is dependent on staff for showers. During a confidential interview on 04/16/24 at 12:09 p.m., Resident #54's family member said she had found Resident #54 wearing clothes with another resident's name more than three times. She did not like seeing Resident #54 in another resident's clothes and told the nurse about it. Resident #54's family member said she does visit the resident at least two times a week, and she should be notified if the resident does not have any clothes. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/18/24 at 1:52 p.m., while incontinent care was provided for Resident #54 by CNA R, it revealed that the resident had off-white pants and multicolored socks with another resident's name on them. During an interview on 04/18/24 at 2:20 p.m., CNA R said that Resident #54 should not be dressed in another resident's clothes because she would not feel good about it, and the resident's family would be upset if they saw it. CNA R said the nurse monitored the aides when she made rounds. CNA R said the aide from night shift aide must have dressed Resident #54. CNA R said she had a skill checkoff on ADLs, which included incontinent care, grooming, and dressing the resident. During an interview on 04/18/24 at 4:59 p.m., Unit Manager L said CNA R should not have dressed Resident #54 in another resident's clothes. The unit manager, L, said it was a dignity issue because it was not acceptable to swap residents' clothes. The Unit manager also said the floor nurses should make rounds and monitor the aides when they provide care for the residents. The unit manager monitored nurses and aides during rounding. During an interview on 04/19/24 at 11:37 a.m., the ADON said CNA R should not put clothes that did not belong to Resident #54 on the resident because it was a dignity issue. The ADON said Resident #54 would not have liked wearing another resident's clothes if she did not have a memory problem, and her family would be upset. The ADON said the nurses monitor the aides, while the unit manager and nurse managers monitor the nurse during rounding. Record review of Resident #148's face sheet dated 04/19/24 revealed a [AGE] year-old female was currently admitted to the facility on [DATE] and readmitted on [DATE]. Resident #148 had diagnoses which included: frontotemporal neurocognitive disorder (result of damage to neurons in the frontal and temporal lobes of the brain), UTI (a condition in which bacteria invade and grow in the urinary tract) and hypertensive heart disease (all direct and indirect sequelae of chronic high blood pressure). Record review of Resident #148's quarterly MDS assessment, dated 03/20/24 revealed: Resident #148 had a BIMS score of 9 out of 15 which indicated impaired cognation. Resident #148's functional status revealed she was dependent on staff with bed mobility, transfer, grooming and toilet use. Record review of Resident #148's care plan 04/16/24 09/04/20 revealed the resident required assistance for all ADL and mobility tasks due to generalized debility weakness, poor endurance, and activity intolerance. Intervention: resident dependent requires on staff for dressing and clothing changes daily, and PRN. Assist resident with shower three times per week per schedule and PRN. Resident is dependent on staff for showers. During an observation on 04/18/24 at 10:01 a.m., CNA H and CNA W provided incontinent care for Resident #148, which revealed that Resident #148 was wearing a brown dress with another resident's name on it. During an interview on 04/18/24 at 12:00 p.m., CNA W said she dressed Resident #148 this morning, and it was Resident #148 because she found it in the resident's closet. When asked if seeing the dress in Resident #148's closet meant it belonged to the resident, she did not respond. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/24 at 12:45 p.m., unit manager C said it was not appropriate for CNA W to have dressed Resident #148 in another resident's clothes. Unit manager C said Resident #148, or a family member would not like the resident in another resident's clothes, and it was a dignity issue. Unit manager C said CNA W should have changed Resident #148's dress as soon as she noticed the resident was wearing another resident's clothes. During an interview on 04/18/24 at 1:19 p.m., LVN S said CNA W was not supposed to dress Resident #148 in another resident's clothes because it was a dignity issue. LVN S said the nurse monitored the aides during rounding. During an interview on 04/19/24 at 10:15 a.m., the DON said residents should wear their clothes. The DON said he did not know how Resident #148 would feel if she knew she had another resident's clothes. The DON said the aides had a skills check-off, which was part of the ADL. The nurses monitored the aides while the unit managers monitored the nurses during the rounds. Record review of facility policy on resident rights dated 2001 MED - PASS, Inc. (Revised December 2016 read in part . Employees shall treat all residents with kindness, respect, and dignity .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #135) of 3 residents reviewed for baseline care plans, in that: The facility failed to ensure Resident #135's baseline care plan was done for Haloperidol (a first-generation typical antipsychotic; is used to treat nervous, emotional, and mental conditions) when ordered on 03/01/24. This failure could place newly admitted residents at risk of not receiving continuity of care and communication among nursing home staff to ensure their immediate care needs are met. Findings included: Record review of the Resident #135 face sheet dated 3/19/24 reflected she was a 73-year -old date of admission was 2/11/2022 and was readmitted on [DATE] and the diagnoses included chronic obstructive pulmonary disease, history of urinary tract infection, schizophrenia (is a brain disorder that can cause people to have abnormal interpretations of reality), paranoid personality disorder(disorder that causes people to have an extreme fear and distrust of others), anxiety disorders (feeling of fear, nervousness or apprehension that can occur when learning), disturbances of salivary secretion, essential disorder, eating disorder, syncope and collapse (fainting or a sudden loss of consciousness), and occlusion and stenosis of right carotid artery(blockage, obstruction and abnormal narrowing of a bodily passage or canal). Review of Resident #135's quarterly MDS Assessment, dated 02/19/24, also reflected she had a BIMS score of 11 (indicating moderate cognitive impairment). Resident #135 was identified as needing ADL assistance including bathing and dressing. Record review of physician order dated 03/01/2023, stated, Haloperidol tablet 1 mg oral every 6 hours, Schizophrenia. Record review of a care plan dated 03/10/2023, stated, Problem (Resident #135) category: Psychotropic drug use : Potential for medication side effects and adverse reactions due to anti-depressant, anti-anxiety and anti-psychotic medication use for required for the management of schizophrenia, Paranoid personality disorder, depression. Intervention/Approach start date: 03/10/2023, monitor antipsychotic side effects and effectiveness. Antipsychotic side effects: Dizzy or blurry vision, drowsiness, weight gain, digestive issue, low blood pressure, restlessness, mental fog, loss of motivation, social withdrawal, uncontrolled movements metabolic syndrome, diabetes. There was no care plan intervention included for the use of Haloperidol. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/16/24 at 9:30 AM, 11:00AM, 1:30 PM, 4:00 PM, and throughout the survey on 4/19/24 Resident #135 was lying in bed and was not responding to any questions asked. Resident #135 was lying shaking. Interview with the MDS coordinator on 4/19/24 at 10:43 AM, regarding baseline care plan for Resident #135 with Haloperidol 1mg every 6 hours, she said the nurse who received the new medication should have done the baseline care plan. During an interview with the Administrator and DON on 04/19/24 at 3:48PM, they stated the expectation was for baseline care plans to be completed upon a resident's admission to the facility and there was any change of medication by the nursing staff completing the admission. The DON stated the risk of a resident's baseline care plan not being completed included staff not knowing how to best care for a resident. The facility's policy regarding baseline care plans was requested from the Administrator on 04/19/24 at 4:57PM but was not provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive care plan for 1 of 5 residents (Resident #76) reviewed for professional standards. The facility failed to ensure nursing staff followed Physician orders for supplement (nutritional supplements) liquid for Resident #76 This failure could place residents at a risk of discomfort and decline in overall health. Findings included: Record review of face sheet dated 4/17/24 for Resident #76 reflected she was a [AGE] year-old female resident who was originally admitted on [DATE]. Her medical diagnoses included Huntington's disease,(nervous system condition caused by the inheritance of an altered gene from a parent) muscle wasting and atrophy (right and left thigh), other lack of coordination, cognitive communication deficit, Major Depressive Disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), hypotension (low blood pressure), history of falling, unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and dysphagia(difficulty swallowing). She was receiving house supplement, 1 carton orally with meals for nutritional deficiency starting 01/11/2024. Record review of a Quarterly MDS dated [DATE] for Resident #76 revealed he had a BIMS score of 00 indicating severe cognitive impairment.). Resident #76 was identified as needing ADL assistance including bathing and dressing . Record review of a Physician order with a date of service 01/11/2024 had House Supplement (Nutritional supplements) liquid 1 carton (237 mls) oral with meals for nutritional deficiency. Record review of Clinical Physician Orders dated 01/11/2024 had House Supplement (Nutritional supplements) liquid 1 carton, oral with meals), 8:00AM, 12:00 PM and 5:00 PM. Record review of a Care Plan for Resident #76 dated 01/13/2024 reflected she had weight loss (1/10/24 weight was 98.6 and weight 12/06/23 = 5%), House Supplement (Nutritional supplements) liquid 1 carton, oral with meals).Further weight loss 02/09/2024 =95.8 lbs,03/08/24 =96.2lbs, 04/10/24=101 and 04/18/24 =99.0 lbs(pounds) Record review of the MAR for Resident #76 dated 01/11/2024 reflected an order for House Supplement (Nutritional supplements) liquid 1 carton, oral with meals 8:00AM, 12:00 PM and 5:00 PM, was signed as being given on by MA. Observation on 04/17/2024 at 8:40 AM revealed Resident #76 ambulating in her room with a head helmet on. MA (Medication aide) B was observed during medication administration, MA B poured Plus Boost 100 ml before meal. Plus Boost contained 37 fluid OZ. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/17/2024 at 9:00 AM with MA B revealed Resident #76's breakfast was served at 9:00 AM and she always give her the Plus Boost in her room before Resident #76 comes to the dining room. Plus Boost contained 37 fluid OZ. Interview on 04/18/2024 at 11:15 AM regarding the amount of Plus Boost Resident #76's was supposed to have. MA B stated Plus Boost It is just part of the medication supplement and I always give 100 ml. MA B was asked why Plus Boost was not given as ordered by the physician and as documented on MAR, to give 1 carton with meal. MA said she very sorry and knew it was to help Resident #76 gain weight. In an interview on 04/18/24 at 5:27 PM the DON stated the nurses should have been following Dr's orders. Plus Boost 1 carton should be given as order to Resident #76 help with weight. She stated not following orders could potentially affect the resident's health. DON said he would be having in-services to ensure that the staff follows physician's order. In an interview on 04/18/2024 at 5:29 PM the ADM (Administrator) stated his expectation was for the nurses to follow Dr's orders and they should have been documenting on the MAR accurately. He stated by signing off on something they did not do it was falsification of records. He stated not following orders could potentially affect the resident's health. No policy and procedure regarding following Physician orders was provided by the ADM prior to exit from the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 2 of 7 residents (Resident #54 and Resident #117) reviewed for ADLs. 1. The facility failed to ensure Resident #54 was provided personal grooming by facility staff. 2. The facility failed to Resident #117 was provided personal hygiene by facility staff. This failure could place residents at risk for not having personal care needs addressed by facility staff resulting in discomfort, and dignity issues. Findings included: Record review of Resident #54's face sheet dated 04/19/24 revealed a [AGE] year-old female was admitted to the facility on [DATE]. Resident #54 had diagnoses which included: Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), dementia (impair ability to remember, think, or make decisions that interferes with doing everyday activities) and hypertensive heart disease (all direct and indirect sequelae of chronic high blood pressure). Record review of Resident #54's quarterly MDS assessment, dated 03/06/24 revealed: Resident #54 had 99 entered for BIMS because Resident # 54 was not able to complete the interview. Resident #54's functional status revealed she was maximal assistance from staff with bed mobility, transfer, grooming and toilet use. Record review of Resident #54's care plan initiated 09/04/20 revealed the resident required assistance for ADL and mobility tasks due to weakness, impaired balance, poor endurance, and activity intolerance. Intervention: requires maximum assistance from staff for dressing and clothing changes daily, and PRN. Assist resident with shower three times per week per schedule and PRN. Resident is dependent on staff for showers. Record review of Resident #54 shower sheets for March and April 2024 revealed the facility was able to provide shower sheets for the following days: 03/01/24, 03/21/24, 03/22/24, and 03/29/24. Record review of Resident # 54's progress noted dated for 03/26/24, 03/27/24, and 03/29/24 revealed Resident #54 refused shower and she was provided bed bath on the days mentioned above. During a confidential interview on 4/16/24 at 12:09 p.m., Resident #54's family member said she was unsure if she gets showers and had found her sometimes dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/17/24 at 9:34 a.m., LVN M looked through the shower binder and said she could only find one shower sheet from February and one for March. LVN M said the shower sheets for the current month should placed in the binder, and when the month ended, the Unit Manager would take the shower sheets from the [NAME]. LVN M said Resident #54 should get her shower at least three times a week, and if the resident refused, the aide would tell the nurse, and the nurse would assess the resident. LVN M said if the resident continues to refuse, the aide will make the shower sheet refuse, and she will sign it and place it in the shower binder. LVN M said she had not signed any shower sheets since she started working in the facility about a week ago. LVN M also said none of the aides had told her Resident #54 refused to shower. She said if Resident #54 wanted to get a shower and it was not given, Resident #54 would feel bad and may have body odor, rashes, or dry skin. LVN M said the nurses monitored the aides during rounding. During an observation and interview on 04/17/24 at 9:56 a.m., Unit Manager L said she was able to find two shower sheets for Resident #54 for March. Unit Manager L said she had gone through all the shower sheets in her office and even went back to previous months to check. Unit Manager L said she could not find any more shower sheets for March and that the April shower sheets should be in the binder at the nurse's station for Resident #54, but she believed the shower sheets for March were placed somewhere else. Then she said we can only do what we can with the number of staff given. When she was asked to explain what she meant, she did not respond. Unit Manager L said if Resident #54 did not get a shower, Resident #54 would feel unkempt and have a body odor, rashes, and dry skin. During an interview on 04/17/24 at 10:09 a.m., CNA R said she had been working in the facility for at least a week and had not given Resident #54 a shower and she was Resident #54 aide for today. CNA R said she had worked with Resident #54 during floor orientation, but she did not shower Resident #54 because the aide who was orienting her did not shower Resident #54. CNA R said Resident #54's shower days were Monday, Wednesday, and Friday. CNA R said if a resident refused or did get a shower, it should be documented on the shower sheet, which will be given to the nurse to sign, and she would place the sheet in the binder. CNA R said Resident #54 could feel bad if she did not get her shower and could have body odor and dry skin. CNA R said she had a skills checkoff, and the nurses monitored the aides during rounding. During an observation on 04/18/24 at 1:52 p.m., CNA R provided incontinent care to Resident #54. When Resident #54's pants were removed, it revealed that she had dry patches and flaky skin from her thigh to her ankle on both legs. During an interview on 04/18/24 at 4:54 p.m., Unit Manager L said Resident #54's skin was dry and flaky, and it could be that she was not drinking enough or did not have enough moisture on her skin. Unit Manager L said the aide should apply lotion on Resident #54 on shower days and as needed. Unit Manager L did not respond when she was asked what could happen to Resident #54's skin when it was dry and flaky. During an interview on 04/18/24 at 5:23 p.m., RN A said the aides did not apply any lotion on Resident #54 skin. RN A said the aides should apply cream on the residents on shower days or when they notice that the resident is dry and flaky. RN A said that when a resident's skin was dry, it could get torn (skin tear) easily. RN A said nurse managers monitor the nurses by asking them questions on how the aides are providing care for the residents, and the nurses monitor the aides by going on the floor with aides. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/19/24 at 11:34 a.m., the ADON said many things could cause Resident #54's skin to become dry and flaky, such as not getting showers, applying lotion, or dehydration. The ADON said Resident #54's dry skin could lead to skin breakdown. The ADON said the nurse monitored the aides while the unit managers monitored the nurse during rounding. Record review of Resident #117's face sheet dated 04/19/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE]. Resident #21 had diagnoses which included: parkinsonism (motor syndrome that manifest as rigidity, and tremors), heart failure (a condition that develops when your heart do not pump enough blood for the body), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activity) Record review of Resident #117's annual MDS assessment, dated 03/16/24 revealed: Resident #117 had a BIMS score of 13 out of 15 which indicated intact cognation. Resident #117's functional status revealed she was dependent on staff with bed dressing transfer, personal hygiene, and toilet use. Record review of Resident #117's care plan edited on 04/1824 read in part . resident is incontinent with uninhabitable bowel and bladder . intervention check on resident at routine intervals to assist with toilet tasks. Resident dependent for toilet tasks/incontinent care . resident refuses to allow staff assist her with ADLs . intervention approach resident in a calm, unhurried manner to better gain compliance . During observation and interview on 04/16/24 at 12:26 a.m., it revealed Resident # 117 was sitting in her wheelchair in her room and dressed in her street clothes. Resident #117 said she wanted to get into her bed, but the linen was wet with urine, the wet brief she wore last night was still on the bed, and another brief was on the floor in the restroom. Resident #117 said she tried to do most of her care, but the staff did not come and check on her most of the time. Resident #17 said she had Parkinson's disease, and when the medication started to wear off, she would become ridged, and she could not do much for herself. During an observation and interview on 04/16/24 at 12:33 p.m., LVN M said the draw sheet and the incontinent brief on the bed were wet with urine, and she stated the incontinent brief on the floor in the restroom was damp, too, with urine. LVN M said CNA G should have checked on Resident #171 after the resident dressed and made sure her bed was not wet and that there were no wet briefs on her bed or on the restroom floor because it was part of ADL care. LVN M said the aides should make rounds every two hours and check on all residents, even if the residents can do it for themselves. LVN M said it was a dignity issue because Resident #117 could not get into her bed because the draw sheet and wet incontinent brief were on her bed. LVN M said the nurse monitored the aides when the nurse made rounds, and the unit manager monitored the nurse. LVN M said she did not notice the brief when she made rounds because she looked into the room, and Resident #117 was not in the room, but she should have looked around the room and made sure her room was clean. During an interview on 04/16/24 at 12:52 p.m., CNA G said Resident #117 does her care by herself, and when she needed assistance, she would call. CNA G said Resident #117 is very alert, and he does not check on her. CNA G said he went into Resident #117's room around 9:00 a.m., and Resident #117 was still in bed, but he had not returned to her room or checked on Resident #117. CNA G said he should have made rounds every two hours. CNA G said he had a skills checkoff and in-service on how to make rounds. CNA G said he was supposed to check on Resident #117's bed and ensure it was clean and dry, but he forgot to go back. (continued on next page)

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	675764	A. Building B. Wing	04/19/2024

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/19/24 at 11:09 a.m., the DON said CNA G should make rounds every two hours to check on Resident #117 and see if she wanted to go to the restroom or make her bed. The DON said that if Resident #117 was independent, she would not be in the facility and that it was the staff's responsibility to check on Resident #117. The DON said it would not be a nice feeling for Resident #117 if her bed linen was wet with urine and wet incontinent brief still on the resident's bed. During an interview on 04/19/24/ at 11:23 a.m., the ADON said CNA G should make rounds every two hours on all the residents and as needed. The ADON said Resident #117 would not feel good if she wanted her bed clean and dry. The DON said it should not be happening because making the resident bed was part of daily ADL care. The ADON said any nursing managing team monitors the aides and ensures that the aides provide care for the resident. Record review of the facility policy on bath dated 09/211 All Rights Reserved read in part .the nursing staff will provide residents with sponge bath to provide a method for the body to col slowly .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 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 2 of 8 residents (Resident #148, and Resident #181) reviewed for incontinent care. 1.The facility failed to ensure CNA H cleaned Resident #148 properly and or followed proper hand hygiene during incontinent care. 2.The facility failed to ensure CNA J followed proper hand hygiene and ensure Resident #181 leg bag was below his bladder during foley care. These failures could place residents at risk for pain, infection, injury, and hospitalization . Findings included: 1. Record review of Resident #148's face sheet dated 04/19/24 revealed a [AGE] year-old female was currently admitted to the facility on [DATE] and readmitted on [DATE]. Resident #148 had diagnoses which included: frontotemporal neurocognitive disorder (result of damage to neurons in the frontal and temporal lobes of the brain), UTI (a condition in which bacteria invade and grow in the urinary tract) and hypertensive heart disease (all direct and indirect sequelae of chronic high blood pressure). Record review of Resident #148's quarterly MDS assessment, dated 03/20/24 revealed: Resident #148 had a BIMS score of 9 out of 15 which indicated impaired cognation. Resident #148's functional status revealed she was dependent on staff with bed mobility, transfer, grooming and toilet use. Record review of Resident #148's care plan edited on 04/16/24 revealed the resident required assistance for all ADL and mobility tasks due to generalized debility weakness, poor endurance, and activity intolerance. Intervention: resident dependent requires on staff for dressing and clothing changes daily, and PRN. Assist resident with shower three times per week per schedule and PRN. Resident is dependent on staff for showers. Further review reveald the resident was incontinent of with uninhibited bowel and bladder. Intervention: check resident at routine intervals to assess and offer assist with toilet tasks. Resident is dependent for toileting tasks/incontinent care. Record review of Resident #148's physician order report dated 03/01/24 through 04/19/24 read in part . nitrofurantoin monohyd/m-cryst (antibiotics for urinary tract infection medication) capsule: 100mg: 1 tab oral twice a day DX: urinary tract infection . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/18/24 at 10:01 a.m., incontinent care was provided for Resident #45 by CNA H and assisted by CNA W. CNA H placed her hand in her uniform packet and pulled up her uniform pants. CNA H did not wash or sanitize her before she donned(putting on gloves) clean gloves and provided and started providing incontinent care for Resident #45. During care, CNA H held the pubic area but did not separate the labia and clean the area, and she kept going into the wipe packet with the glove, which she was using to clean Resident #45's bowel movement. CNA H said she finished cleaning Resident #45, but there were areas on Resident #45 buttocks that had bowel movements. When the surveyor intervened, CNA H was about to apply barrier cream and clean the incontinent brief on Resident #45. CNA H then separated Resident #45 labia and wiped it three times, and she wiped out the yellow and brown substance. CNA H wiped the buttocks three times, and there was a substantial amount of bowel movements. During an interview on 04/18/24 at 11:36 a.m., CNA H said she was supposed to wash or sanitize her hands before she donned gloves because it was infection control. CNA H stated her hands were not clean after she had touched her uniform. CNA H said she thought she separated Resident #148's labia but realized she did not when she cleaned out a brown substance from Resident #148's labia area. CNA H also said she had to clean the buttocks three times, and there was a bowel movement. CNA H said if she did not clean Resident #148 correctly, the resident could get an infection and skin breakdown. CNA H said she went into the wipe container with the gloved hand, which she was cleaning bowel movement, and that was cross-contamination. CNA H stated she had skills checkoff, which included peri care, and the nurses monitored the aides during rounding. During an interview on 04/18/24 at 11:50 a.m., CNA W said she did not remember if CNA H sanitized her hands before putting on gloves. CNA W said CNA H held Resident #148's pubic area and did not separate the labia and wiped it. CNA W said Resident 148 still had bowel movements on her buttocks, and CNA H was about to apply barrier cream and brief when the surveyor intervened. CNA H wiped Resident #148 and the wipes had a lot of bowel movement. CNA W said if Resident #148 was not appropriately cleaned the resident could get infection. CNA W said she had in-service on hand washing and peri care, and the nurses monitored the aides during the rounds. During an interview on 04/18/24 at 12:41 p.m., Unit Manager C said her expatiation from CNA H was to separate Resident#148 labia and clean the side, side, and center to ensure the area was cleaned appropriately. Unit Manager C said if CNA H did not clean Resident #148 correctly, she could have an infection such as a UTI and possible yeast infection. Unit Manager said CNA H should have cleaned Resident #148 buttocks thoroughly before she applied [NAME] cream. Unit manager C said CNA H should not have gone into the clean wipe container because it could be infection control: cross-contamination. Unit manager C said if Resident #148's skin was not completely clean of BM, it could cause skin irritation or infection. During an interview on 04/18/24 at 1:19 p.m., LVN S said the nurse monitors the aides and ensures they provide care for the resident. LVN S said CNA H was supposed to separate the labia area and wipe from front to back. LVN S said Resident #148 could get an infection, such as a UTI. LVN S said CAN H should have removed her gloves and sanitized her hands when she went from dirty to clean. She should not have used the dirty gloves to pull wipes from the wipe packet. LVN S said the unit manager monitors the nurses during rounding. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/19/24 at 10:19 a.m., the DON said CNA H should have sanitized her hands after she touched her uniform before she donned gloves and provided care for Resident #148. The DON said CNA H should have separated Resident #148 labia, cleaned side, side, and then center, and ensured the area was clean thoroughly to prevent Resident#148 from getting infected in the long run. The DON said the nurse monitored the aides during rounds, and the unit managers monitored the nurse during rounds. 2. Record review of Resident #181's face sheet dated 04/04/24 revealed a [AGE] year-old male admitted to the facility on [DATE]and readmitted on [DATE]. Resident #181 had diagnoses which included: dementia (impaired ability to remember, think, or make decisions that interferes with doing every day activities), obstructive and reflux uropathy, (when urine cannot drain through the urinary tract), benign prostatic hyperplasia (overgrowth of prostate tissue pushes against the urethra and bladder blocking the flow of urine) and urinary tract infection(bacteria invade and grow in the urinary tract(kidneys, ureters, bladder, and urethra)). Record review of Resident #181's quarterly MDS assessment, dated 02/06/24 revealed: Resident #181 had a BIMS score of 07 out of 15 which indicated severely impaired cognation. Resident #181's functional status revealed he was independent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident#181 had an indwelling foley catheter. Record review of Resident #181's care plan edited 02/18/24 read in part . resident requires foley catheter due to BPH with lower urinary tract symptoms, urinary retention . Intervention keep catheter free from kinks and drainage bag lower than bladder at all times .revealed the resident was at risk for infection related to indwelling catheter, DX: Neurogenic bladder. Intervention: keep tubing below the bladder and free of kinks or twists. Record review of Resident #181's physician order dated from December 2023 through April 2024 read in part . change Foley catheter with 18 inch catheter and 10cc bulb on the 1st of each month dated 12/22/23 and DC 02/06/24 . the resident has to go to a neurologist to get his foley catheter changed once a month FYI dated 02/06/24 . keep catheter from kinks and drainage bag lower than bladder at all times dated 12/22/24 . Bactrim DS tablet 800-160 mg 1 tablet x 7 days DX: urinary tract infection order date 01/27 24 - 02/03/24 . Bactrim DS tablet 800-160 mg 1 tab oral DX encounter for prophylactic measures dated 03/04/24 - 03/09/24 . During an observation on 04/18/24 at 2:35 p.m., Foley care was provided for Resident #181 [NAME] by CNA J and assisted by CAN R. CNA R used the same gloves from the beginning to the end of Foley care for Resident #181. CNA J donned gloves assisted Resident #181 to bed and took off his pants and incontinent brief. CNA J, still wearing the same glove, went and placed the brief in a trash can, and pushed the brief down inside the trash can. CNA J took the wipe packet from the top of the chest and placed it on the TV stand. CNA J, still wearing the same gloves, pulled wipes from the wipe packet, and provided Foley care for Resident#181, and he pulled wipes from the container seven times with the same dirty gloves. Resident #181 had his Foley catheter leg bag on while he lay down in bed, and the urine in the bag flowed backward toward the bladder, and the bag appeared flat. After CNA J provided care and Resident #181 sat on the edge of the bed, the urine started to flow downward. CNA J emptied the leg bag, and there was 250 ML of urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/24 at 2:50 p.m., Resident #181 was not able to state whether he wore a Foley catheter leg bag while in bed. During an interview on 04/18/24 at 2:58 p.m., CNA J said he did not change his gloves throughout the Foley care. CNA J said he used the same gloves and took wipes from the wipe packet, which caused cross-contamination. CNA J said Resident #181 always wore foley leg bag and he did not know why but the nurse would know. CNA J said he had in service on Foley care and infection control. During an interview on 04/18/24 at 3:09 p.m., Unit Manager L said when Resident #181 came to the facility, he had the Foley big bag and kept taking it off and putting it in the dresser. Unit manager L said Resident#181 went to the hospital in January on 01/28/23 and February 02/09/24 because he pulled the Foley catheter off. Unit Manager L said Resident #181 was better off with the leg bag, and she said the urine would not flow back to the bladder because the leg bag flows only one way. The unit manager said that even if the urine flowed back to the bladder, it was still better because Resident #181 removed the leg bag less than the big bag. Unit manager L said CNA J should have changed the use gloves before CNA J went into the wipe box. Unit manager L said it was an infection control: cross-contamination. During an interview on 04/18/24 at 5:16 p.m., Resident #181 provider said in his professional opinion, Resident #181 could go to bed with a Foley leg bag, and he had no problem. The provider said you should not be given anybody IJ because of the Foley bag, and he asked the surveyor to tell him what to write and that he would write the order. The provider said he could write the order for the leg bag to be hung below the bladder at night while Resident #181 slept to prevent the urine from flowing back into his bladder. During an interview on 04/18/24 at 5:48 p.m., RN A said Resident 181 had a Foley bag hung on the bed rail, but he always takes it out. RN A said about 2 to 3 weeks after he came to the facility, Resident #181 pulled the Foley out and was sent to the hospital. RN A said Resident #181 also takes the leg bag off because he knows how to disconnect it. RN A said the night Resident #181 came, he pulled the Foley out and was sent to the hospital. RN A said she could not remember which nurse called Resident #181's provider, and he gave the order to put Resident #181 on a foley leg bag. RN A said she did not know if Resident #181 was supposed to lie in bed with it because the urine could flow back to the bladder, which could cause infection. During an interview on 04/19/24 at 10:24 a.m., the DON said the Foley leg bag could flow back into Resident #181 just as the big bag if it was kept at the same level as the bladder. The DON said if the urine flowed back into Resident #181's bladder, it could cause UTI. The DON said the facility would instead go with the leg bag because the Resident pulls it off less than the big bag, and the unit manager would know more about it. The DON said CNA J should have changed his gloves before going from dirty to clean. The DON said CNA J contaminated the wipes in the packet. Record review of the facility policy on peri care dated 3/2006 A Right Reserved read in part . staff will provide cleanliness of genitalia to avoid skin breakdown and infection . for female/resident A#3 . separate labia to expose urethra meatus and virginal orifice . Record review of the facility policy on catheter /urinary catheter dated 07/2009 all Rights Reserved did not reveal placement of a foley catheter bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CDC.gov website CAUTI 104 (cdc.gov) read in part . Maintain the bag below the level of the bladder .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review, the facility failed to the accurately, dispensing, and administering of all drugs and biologicals to meet the needs of 2 of 11 residents (Resident #48 and Resident #176) reviewed for pharmacy services, in that: - Resident #48 was not administered Gingko biloba medications per the physicians order. - Residents #176 was not administered Omeprazole oral medications per the physicians order. These failures could affect residents who are administered medication and placed them at risk of not receiving the intended therapeutic benefit of their medications and decline in health. The findings include: Record review of Resident #176's Face sheet dated 04/19/24 reflected a [AGE] year-old male resident who was originally admitted on [DATE]. His medical diagnoses included 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),psychotic disturbance (when people lose some contact with reality), mood disturbance, and anxiety), metabolic encephalopathy(a problem in the brain, caused by a chemical imbalance in the blood) cognitive communication deficit, dysphagia, and type 2 diabetes mellitus (onset of adult diabetes, high glucose level in the blood), Gastro-esophageal reflux disease without esophagitis (condition where stomach content moves up into the esophagus). Record review of Resident #176's Quarterly MDS assessment, dated 01/30/24, revealed a BIMS score of 09, which indicated he was moderately cognitively impaired. Record review of Resident #176's Physician's order Summary report dated 11/24/23, reflected Resident #176 was to receive the following medications daily: omeprazole (1 capsule, delayed released) 40 mg 1 tablet at 6:30 AM Record review Resident#176 was receiving omeprazole (1 capsule, delayed released) 40 mg once a day starting 11/24/2023 for Gastro-esophageal reflux disease without esophagitis. Record review Resident #176's MAR dated 4/1/24 the resident received the medication at 6:30am daily. MA B had initialed on 4/17/24 for 6:30AM. During an observation on 04/17/24 at 8:45 AM, MA B administered omeprazole (1 capsule, delayed released) 40 mg for Resident #176, she opened the Omeprazole 40 mg 1 capsule and sprinkled in jelly and administered by mouth to Resident #176. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MA B on 04/18/24 at 9:50 AM, regarding Omeprazole 40 mg given on 04/16/24 at 8:45 AM, MA B said she always gave Resident #176 Omeprazole 40 mg at the same time and she did not realized it should have been given at 6:30 AM. MA B said she was very sorry and she knew to follow medication as ordered by the physician. She said she had in-services on medication administration by the DON. Record review of Resident #48's Face sheet, dated 04/19/24 was a [AGE] year-old female resident who was originally admitted on [DATE]. Her medical diagnoses included other symptoms and signs involving the musculoskeletal system (supports you and helps you move), acute bronchitis (a prevalent respiratory infection), schizoaffective disorder, hypoglycemia (low blood sugar) vitamin D deficiency, and anxiety disorder. Record review of Resident #48's Quarterly MDS assessment, dated 01/31/24, revealed a BIMS score of 09, which indicated she was moderately cognitively impaired. Record review of Resident #48's Physician's order Summary report dated 11/29/23, reflected Resident #48 was to receive the following medications daily: Ginkgo Biloba 3000mg 1 tablet oral three times a day. Record review Resident # 48's MAR dated 4/1/24 the resident received the medication Ginkgo Biloba 3000mg 1 tablet oral three times a day (given daily at: 8:00AM,12:00 PM and 4:00 PM) Record review of Resident #48 MAR reflected resident was receiving ginkgo biloba 3000 mg 1 tablet three times a day for vitamin deficiency starting 11/29/2023 and discontinued 04/18/2024. Per their MAR/TAR for April 2024, the resident received the medication at 8:00 AM, 12:00 PM, and 4:00 PM daily. Observation on 04/16/24 at 11:47 AM, MA A administered Ginkgo biloba 120 mg for Resident #48, he picked up a bottle of Ginkgo biloba 120 mg 1 tablet and administered it by mouth to Resident #48 . It was the only Ginkgo biloba bottle in the medication cart. During an interview with MA A on 04/18/24 at 11:02 AM, regarding administered Ginkgo biloba 120 mg for mg given on 04/16/24 at 11:47 AM and was shown the bottle of Ginkgo biloba from the medication cart and MAR that had Ginkgo biloba 3000 mg to be administered to Resident #48. MA A said he was just helping in the unit to administered medication, he was not aware Ginkgo biloba comes in 3000 mg. DON was called by the surveyor to medication cart. In an interview with the DON on 4/18/24 at 11:05 AM, after checking Gingko biloba MAR and physician order's and medication bottle, the DON said it was transcription error, he would notify the physician to adjust Gingko Biloba. He said the DON and ADON monitored the nurse when they made random rounds for medication administration. Record review of the facility's policy titled, Rights of Medication Administration, no date, read in part . Check the medication label.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on interview and record review, the facility failed to ensure residents' pharmacist medication regimen review recommendations were reviewed by the resident's attending physician and what, if any, action has been taken to address them, for 1 of 5 residents (Residents #135) whose records were reviewed for pharmacy services. The facility failed to ensure the physician provided a clinical rationale in response to the consulting pharmacist's recommended changes during the medication regimen review. This failure could place residents at risk for significant health status declines. The findings included: Record review of the Resident #135 face sheet dated 3/19/24 reflected she was a 73-year -old date of admission was 2/11/2022 and was readmitted on [DATE] and the diagnoses included chronic obstructive pulmonary disease, history of urinary tract infection, schizophrenia (is a brain disorder that can cause people to have abnormal interpretations of reality), paranoid personality disorder(disorder that causes people to have an extreme fear and distrust of others), anxiety disorders (feeling of fear, nervousness or apprehension that can occur when learning), disturbances of salivary secretion, essential disorder, eating disorder, syncope and collapse (fainting or a sudden loss of consciousness), and occlusion and stenosis of right carotid artery (blockage, obstruction and abnormal narrowing of a bodily passage or canal). Review of Resident #135's quarterly MDS Assessment, dated 02/19/24, also reflected she had a BIMS score of 11 indicating moderate cognitive impairment.). Resident #135 was identified as needing ADL assistance including bathing and dressing. Review of Resident #135's physician's orders reflected an order for: Seroquel Oral Tablet 50 MG (Quetiapine Fumarate), Give 1 tablet by mouth three times a day,(with a start date of 12/16/2022) Haloperidol 1mg, Give 1 tablet by mouth every 6 hours (with a start date of 03/01/23) for psychosis related to other specified persistent mood disorders and Paroxetine HCL 40mg, Give 1 tablet by mouth once a day for anxiety with a start date of 10/27/23. Record review of Resident #135's Medication Regimen Review (MRR) dated 03/14/23, reflected a recommendation by the consulting pharmacist to physician, to consider Per guidelines, recommend evaluate for a potential dose reduction if not clinically contraindicated at this time. If no changes made, recommend document clinical contraindication and continued benefit to the Resident #135 for the following medications: Seroquel 50mg lid since 12/16/22 -Haloperidol 1mg q 6 hrs. since 03/1/23 -Paroxetine 40mg daily since GDR on 10/27/23 (continued on next page)

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	675764	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	To which the physician checked the decline box without any details in the description section. Interview on 04/19/24 at 4:08 PM with the DON revealed she was aware was a requirement for psychotropic medications. The DON said regarding the pharmacy consultant recommendations that she was primarily responsible for following up on them. The DON stated it was her expectation at the time that the physician provides a clinical rationale for declining a recommendation and stated the risk with not doing so would be that the medication reviews might not be fully reviewed. Interview on 04/19/2024 at 4:16 PM, the ADM stated he was aware this was a requirement and stated he believed the potential risk of the physician not providing a precise clinical rationale could be that the medication might not be reviewed adequately by a medical doctor. A medication administration policy was requested administrator on 04/19/24 at 4:30 PM, but not provided prior to exit.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on interviews and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring) for 1 (Resident # 135) of 5 residents reviewed for unnecessary meds in that: 1. The facility failed to ensure Resident #135 had behavior monitoring for Haloperidol (a first-generation typical antipsychotic; is used to treat nervous, emotional, and mental conditions). 2.The facility failed to ensure Resident #135 had side effect monitoring for Seroquel 3. The facility failed to ensure Resident #135 had documented behaviors to justify administration of Paroxetine Hcl and effectiveness of administration. These failures could place residents at risk of possible medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: Record review of the Resident #135 face sheet dated 3/19/24 reflected she was a 73-year -old date of admission was 2/11/2022 and was readmitted on [DATE] and the diagnoses included chronic obstructive pulmonary disease, history of urinary tract infection, schizophrenia (is a brain disorder that can cause people to have abnormal interpretations of reality), paranoid personality disorder(disorder that causes people to have an extreme fear and distrust of others), anxiety disorders (feeling of fear, nervousness or apprehension that can occur when learning), disturbances of salivary secretion, essential disorder, eating disorder, syncope and collapse (fainting or a sudden loss of consciousness), and occlusion and stenosis of right carotid artery (blockage, obstruction and abnormal narrowing of a bodily passage or canal). Review of Resident #135's quarterly MDS Assessment, dated 02/19/24, also reflected she had a BIMS score of 11 indicating moderate cognitive impairment.). The MDS indicated Resident #135 was dependent on staff for toileting, hygiene, showering or bathing herself, required moderate assistance for oral hygiene, and supervision for eating. Review of Resident #135's physician's orders reflected an order for: Seroquel Oral Tablet 50 MG (Quetiapine Fumarate), Give 1 tablet by mouth three times a day,(with a start date of 12/16/2022) Haloperidol 1mg, Give 1 tablet by mouth every 6 hours (with a start date of 03/01/23) for psychosis related to other specified persistent mood disorders and Paroxetine HCL 40mg, Give 1 tablet by mouth once a day for anxiety with a start date of 10/27/23. Record review of a care plan dated 03/14/24 indicated Resident #135 was at risk for the development of complications related to receiving psychotropic medications. Interventions included assess the reason to need the medication and reevaluate as needed, monitor, and document all behaviors, and observe for side effects and adverse reactions of medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #135's MAR dated 04/01/24-04/19/24 indicated Seroquel Oral Tablet 50 MG (Quetiapine Fumarate), Give 1 tablet by mouth three times a day, (with a start date of 12/16/2022). Haloperidol 1mg, Give 1 tablet by mouth every 6 hours (with a start date of 03/01/23) for psychosis related to other specified persistent mood disorders and Paroxetine HCL 40mg, Give 1 tablet by mouth once a day for anxiety. The MAR for 1/1/24 through 1/31/24, 3/1/24 through 3/1/24, 4/1/24 through 4/18/24 did not have Resident #135's behavior monitoring for signs and symptoms of anxiety or agitation or monitor for sign and symptoms of antipsychotic side effects. Record review of Resident #135's nurse's notes dated 04/01/24-04/18/24 did not reveal behaviors, non-pharmacological intervention used, or effectiveness of administration of Haloperidol 1mg every 6 hour, Seroquel Oral Tablet 50 MG (Quetiapine Fumarate), Give 1 tablet by mouth three times a day. Paroxetine HCL 40mg, Give 1 tablet by mouth once a day for anxiety Observations on 4/16/24 at 9:30 AM, 11:00AM, 1:30 PM, 4:00 PM, and throughout the survey on 4/19/24 Resident #135 was lying in bed and was not responding to any questions asked. Resident #135 was lying shaking with oxygen at 3.5L/min via nasal cannula. During an interview on 04/19/24 at 10:48 AM, the Unit manager about Resident #135's behavior monitoring and if resident had any behavior, she said Resident #135 yelled sometimes. Unit manager then checked Resident active cart, she only found behavior monitoring for 2/1/24 to 2/29/24. She said psychotropic medication should have behavior monitoring intervention used before it was given and keep track if the resident had adverse reaction . During an interview on 04/19/24 at 2:30 p.m., the DON said the admission nurse was responsible to put orders in for behavior and side effects monitoring. She said when psychotropic medication was given it was supposed to documented why it was given on a nurse's note, on the MAR, and TAR behavior monitoring. She said it was important to document behaviors and side effect monitoring to know if it was effective and observe for adverse reactions. Behavior Monitoring documentation was requested for Resident #135 from DON on 04/19/24 at 2:30PM. None was provided prior to exit on 04/19/24. Interview with MDS coordinator on 4/19/24 at 4:31 PM regarding Resident #135's behavior monitoring for psychotropic medications, if she had seen resident being aggressive to any staff . She said sometimes Resident #135 was verbally aggressive, I've only been here a year and only saw her be aggressive to me once. She cursed me out and tried to run me over with her wheelchair. It was couple of months ago, sometime last year (2023). I went back a week later, and she was okay and didn't even remember it and it was reported to anyone or documented. During an interview on 04/19/24 at 4:00 PM, the ADM said behavior and side effect monitoring should be done for psychotropic medications. He said chart audits would be done on residents on psychotropic medications regarding behavior monitoring. He said he expected nursing staffs (unit managers) to document behavior and intervention when the medication was given. He said it was important because it was to track if the medication is needed and if it worked.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review the facility failed to ensure the medication error rate was not 5% or greater. The facility had a medication error rate of 5%, based on 2 errors of 40 opportunities, which involved two of eleven residents (Residents #48 and #176) and one of three staff reviewed for medication errors in that-. 1. MA A failed to administer Resident #48's Ginkgo Biloba (increasing ocular blood flow and potentially halting the progression of visual field loss) 3000 mg on 04/16/24 as ordered by the physician. 2. MA F failed to administer Resident #176's Omeprazole (acid inhibitor) 40 mg on 04/17/24 as ordered by the physician. This failure could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings include: Record review of Resident #176's Face sheet dated 04/19/24 reflected a [AGE] year-old male resident who was originally admitted on [DATE]. His medical diagnoses included 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), psychotic disturbance (when people lose some contact with reality), mood disturbance, and anxiety), metabolic encephalopathy (a problem in the brain, caused by a chemical imbalance in the blood) cognitive communication deficit, dysphagia , and type 2 diabetes mellitus (onset of adult diabetes, high glucose level in the blood), Gastro-esophageal reflux disease without esophagitis (condition where stomach content moves up into the esophagus). Record review of Resident #176's Quarterly MDS assessment, dated 01/30/24, revealed a BIMS score of 09, which indicated he was moderately cognitively impaired. Record review of Resident #176's Physician's order Summary report dated 11/24/23, reflected Resident #176 was to receive the following medications daily: omeprazole (1 capsule, delayed released) 40 mg 1 tablet at 6:30 AM Record review Resident#176 was receiving omeprazole (1 capsule, delayed released) 40 mg once a day starting 11/24/2023 for Gastro-esophageal reflux disease without esophagitis. Record review Resident #176's MAR dated 4/1/24 the resident received the medication at 6:30am daily. MA B had initialed on 4/17/24 for 6:30AM. During an observation on 04/17/24 at 8:45 AM, MA B administered omeprazole (1 capsule, delayed released) 40 mg for Resident #176, she opened Omeprazole 40 mg 1 capsule and sprinkled it in jelly and administered by mouth to Resident #176. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MA B on 04/18/24 at 9:50 AM, regarding Omeprazole 40 mg given on 04/16/24 at 8:45 AM, MA B said she always gave Resident #176 Omeprazole 40 mg at the same time and she did not realized it should have been given at 6:30 AM. MA B said she was very sorry and she knew to follow medication as ordered by the physician and right time. She said she had in-services on medication administration by the DON. Record review of Resident #48's Face sheet, dated 04/19/24 was a [AGE] year-old female resident who was originally admitted on [DATE]. Her medical diagnoses included other symptoms and signs involving the musculoskeletal system (supports you and helps you move), acute bronchitis (a prevalent respiratory infection), schizoaffective disorder , hypoglycemia (low blood sugar) vitamin D deficiency, and anxiety disorder. Record review of Resident #48's Quarterly MDS assessment, dated 01/31/24, revealed a BIMS score of 09, which indicated she was moderately cognitively impaired. Record review of Resident #48's Physician's order Summary report dated 11/29/23, reflected Resident #48 was to receive the following medications daily: Ginkgo Biloba 3000mg 1 tablet oral three times a day. Record review Resident #'s MAR dated 4/1/24 the resident received the medication Ginkgo Biloba 3000mg 1 tablet oral three times a day (given : 8:00AM,12:00 PM and 4:00 PM) Record review of Resident #48 reflected resident was receiving ginkgo biloba 3000 mg 1 tablet three times a day for vitamin deficiency starting 11/29/2023 and discontinued 04/18/2024. Per their MAR/TAR for April 2024, the resident received the medication at 8:00 AM, 12:00 PM, and 4:00 PM daily. Observation on 04/16/24 at 11:47 AM, MA A administered Ginkgo biloba 120 mg for Resident #48, he picked up a bottle of Ginkgo biloba 120 mg 1 tablet and administered by mouth to Resident #48 . The medication cart had one bottle of Ginkgo biloba. During an interview with MA A on 04/18/24 at 11:02 AM, regarding administered Ginkgo biloba 120 mg for mg given on 04/16/24 at 11:47 AM and was shown the bottle of Ginkgo biloba from the medication cart and MAR that had Ginkgo biloba 3000 mg to be administered to Resident #48. MA A said he was just helping in the unit to administered medication, he was not aware Ginkgo biloba comes in 3000 mg. DON was called by the surveyor. In an interview with the DON on 4/18/24 at 11:05 AM, after checking Gingko biloba MAR and physician order's and medication bottle, the DON said it was transcription erro r, he would notify the physician to adjust Gingko Biloba. He said the DON and ADON monitored the nurse when they made random rounds for medication administration. He stated failure to administer the medications as order and at the right time could impact the resident's health depending on the medication. Record review of the facility's policy titled, Rights of Medication Administration, no date, read in part . Check the medication label.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35897 Based on observation, record review and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to maintain proper temperature for food in the breakfast tray line serving cart. 2. The facility failed to ensure food was safely always stored in designated areas. These failures could place residents who ate food from the kitchen at risk of food borne illness and disease. Findings Included: Observation and record temperature of the facility's food on the breakfast tray line serving cart on 04/16/24 at 8:15 AM revealed it was below the recommended temperature. During the observation dietary cook, A took food temperature. Temperature of food taken were as follow: 1. 1pan of turkey Sausage: 120 degrees Fahrenheit. 2. 1/2 a pan of chopped Sausage: 128 degrees Fahrenheit 3. 1/2 a pan of Pureed sausage: 120 degrees Fahrenheit 4. 1/2 a pan of pureed scrambled eggs: 130 degrees Fahrenheit. 5. Vanilla Pudding: 55 degrees Fahrenheit 6. Yogurt: 45 degrees Fahrenheit 7. Milk: 45 degrees Fahrenheit. The facility failed to store several cases of food off the floor delivered the day before. Observation of the facility storeroom on 04/16/24 at 8:20 AM revealed several cases of dry goods stored on the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietary Food Service Manager on 04/16/24 at 8:25 AM she stated that she is responsible in making sure that proper food temperature is maintained during serving time. The food temperature was in the danger zone' indicating bacteria and other foodborne pathogen can grow quickly in the temperature - The Danger Zone' was 41 to 135 degrees Fahrenheit. Proper holding of food is critical for resident safety and wellness. During observation and interview with the Dietary Food Service Manager on 04/16/24 at 8:30 AM she stated that food supply order was delivered yesterday afternoon and she did not have the staff and time to put the delivered items in the designated area. Record review of the facility's policies and procedures for Safe Food Handling dated 10/2009 read in part 4. All foods are stored, prepared, and served at temperatures that prevent bacterial growth. Hot foods are maintained at 140 degrees Fahrenheit or higher and cold foods are maintained at 40 degrees Fahrenheit or below. At point of service. Record review of the facility's policies and procedures for Food Safety in receiving and storage Dry Storage Guidelines dated 10/2009 read in part 1. Store foods at least 6 inches off the floor which is free of contaminants.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 35897 Based on observation, interview and record review the facility failed to dispose of garbage and refuse properly for 1 of 2 dumpster reviewed for Food and nutrition services. -The facility failed to ensure the dumpster lids and doors were secured. This failure could place residents at risk of infection from improperly disposed garbage. Findings included: Observation on 04-16-24 at 8:45 am, revealed the facility's dumpster area, which was in the lot behind the dietary department had a commercial -size dumpster 3/4 full of garbage and the door was open. In an interview on 04-16-24 at 8:45 am, with the Food Service Manager, she stated that the dumpster doors must always be closed to keep vermin, pests, and insects out of the dumpster and from entering the facility. She further stated that housekeeping, and nursing also discard their waste garbage in the dumpster. It is the responsibility of staff from dietary, nursing and housekeeping for ensuring the dumpster doors are kept closed. Dumpster doors are monitored by dietary, nursing and housekeeping as they put waste in the dumpster. Record review of facility's Nutrition Services Policies and Procedures on waste disposal dated 10/2009 revealed that waste will be disposed of in a manner to prevent transmission of disease, nuisance or breeding place for insects and feeding places for rodents and other mammals.5.Waste containers and dumpsters have lids covering them when not in use and not overflowing.

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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** 36918 Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 2 of 8 Residents (Resident #148, Resident #181) reviewed for infection control practices, in that: 1.The facility failed to ensure CNA H cleaned Resident #148 properly and or followed proper hand hygiene during incontinent care. 2.The facility failed to ensure CNA J followed proper hand hygiene and ensure Resident #181 leg bag was below his bladder during foley care. These failures could place residents at risk for pain, infection, injury, and hospitalization . Findings included: 1. Record review of Resident #148's face sheet dated 04/19/24 revealed a [AGE] year-old female was currently admitted to the facility on [DATE] and readmitted on [DATE]. Resident #148 had diagnoses which included: frontotemporal neurocognitive disorder (result of damage to neurons in the frontal and temporal lobes of the brain), UTI (a condition in which bacteria invade and grow in the urinary tract) and hypertensive heart disease (all direct and indirect sequelae of chronic high blood pressure). Record review of Resident #148's quarterly MDS assessment, dated 03/20/24 revealed: Resident #148 had a BIMS score of 9 out of 15 which indicated impaired cognation. Resident #148's functional status revealed she was dependent on staff with bed mobility, transfer, grooming and toilet use. Record review of Resident #148's care plan edited on 04/16/24 revealed the resident required assistance for all ADL and mobility tasks due to generalized debility weakness, poor endurance, and activity intolerance. Intervention: resident dependent requires on staff for dressing and clothing changes daily, and PRN. Assist resident with shower three times per week per schedule and PRN. Resident is dependent on staff for showers. Further review reveald the resident was incontinent of with uninhibited bowel and bladder. Intervention: check resident at routine intervals to assess and offer assist with toilet tasks. Resident is dependent for toileting tasks/incontinent care. Record review of Resident #148's physician order report dated 03/01/24 through 04/19/24 read in part . nitrofurantoin monohyd/m-cryst (antibiotics for urinary tract infection medication) capsule: 100mg: 1 tab oral twice a day DX: urinary tract infection . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/18/24 at 10:01 a.m., incontinent care was provided for Resident #45 by CNA H and assisted by CNA W. CNA H placed her hand in her uniform packet and pulled up her uniform pants. CNA H did not wash or sanitize her before she donned(putting on gloves) clean gloves and provided and started providing incontinent care for Resident #45. During care, CNA H held the pubic area but did not separate the labia and clean the area, and she kept going into the wipe packet with the glove, which she was using to clean Resident #45's bowel movement. CNA H said she finished cleaning Resident #45, but there were areas on Resident #45 buttocks that had bowel movements. When the surveyor intervened, CNA H was about to apply barrier cream and clean the incontinent brief on Resident #45. CNA H then separated Resident #45 labia and wiped it three times, and she wiped out the yellow and brown substance. CNA H wiped the buttocks three times, and there was a substantial amount of bowel movements. During an interview on 04/18/24 at 11:36 a.m., CNA H said she was supposed to wash or sanitize her hands before she donned gloves because it was infection control. CNA H stated her hands were not clean after she had touched her uniform. CNA H said she thought she separated Resident #148's labia but realized she did not when she cleaned out a brown substance from Resident #148's labia area. CNA H also said she had to clean the buttocks three times, and there was a bowel movement. CNA H said if she did not clean Resident #148 correctly, the resident could get an infection and skin breakdown. CNA H said she went into the wipe container with the gloved hand, which she was cleaning bowel movement, and that was cross-contamination. CNA H stated she had skills checkoff, which included peri care, and the nurses monitored the aides during rounding. During an interview on 04/18/24 at 11:50 a.m., CNA W said she did not remember if CNA H sanitized her hands before putting on gloves. CNA W said CNA H held Resident #148's pubic area and did not separate the labia and wiped it. CNA W said Resident 148 still had bowel movements on her buttocks, and CNA H was about to apply barrier cream and brief when the surveyor intervened. CNA H wiped Resident #148 and the wipes had a lot of bowel movement. CNA W said if Resident #148 was not appropriately cleaned the resident could get infection. CNA W said she had in-service on hand washing and peri care, and the nurses monitored the aides during the rounds. During an interview on 04/18/24 at 12:41 p.m., Unit Manager C said her expatiation from CNA H was to separate Resident#148 labia and clean the side, side, and center to ensure the area was cleaned appropriately. Unit Manager C said if CNA H did not clean Resident #148 correctly, she could have an infection such as a UTI and possible yeast infection. Unit Manager said CNA H should have cleaned Resident #148 buttocks thoroughly before she applied [NAME] cream. Unit manager C said CNA H should not have gone into the clean wipe container because it could be infection control: cross-contamination. Unit manager C said if Resident #148's skin was not completely clean of BM, it could cause skin irritation or infection. During an interview on 04/18/24 at 1:19 p.m., LVN S said the nurse monitors the aides and ensures they provide care for the resident. LVN S said CNA H was supposed to separate the labia area and wipe from front to back. LVN S said Resident #148 could get an infection, such as a UTI. LVN S said CAN H should have removed her gloves and sanitized her hands when she went from dirty to clean. She should not have used the dirty gloves to pull wipes from the wipe packet. LVN S said the unit manager monitors the nurses during rounding. (continued on next page)

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	04/19/2024

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/19/24 at 10:19 a.m., the DON said CNA H should have sanitized her hands after she touched her uniform before she donned gloves and provided care for Resident #148. The DON said CNA H should have separated Resident #148 labia, cleaned side, side, and then center, and ensured the area was clean thoroughly to prevent Resident#148 from getting infected in the long run. The DON said the nurse monitored the aides during rounds, and the unit managers monitored the nurse during rounds. 2. Record review of Resident #181's face sheet dated 04/04/24 revealed a [AGE] year-old male admitted to the facility on [DATE]and readmitted on [DATE]. Resident #181 had diagnoses which included: dementia (impaired ability to remember, think, or make decisions that interferes with doing every day activities), obstructive and reflux uropathy, (when urine cannot drain through the urinary tract), benign prostatic hyperplasia (overgrowth of prostate tissue pushes against the urethra and bladder blocking the flow of urine) and urinary tract infection(bacteria invade and grow in the urinary tract(kidneys, ureters, bladder, and urethra)). Record review of Resident #181's quarterly MDS assessment, dated 02/06/24 revealed: Resident #181 had a BIMS score of 07 out of 15 which indicated severely impaired cognation. Resident #181's functional status revealed he was independent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident#181 had an indwelling foley catheter. Record review of Resident #181's care plan edited 02/18/24 read in part . resident requires foley catheter due to BPH with lower urinary tract symptoms, urinary retention . Intervention keep catheter free from kinks and drainage bag lower than bladder at all times .revealed the resident was at risk for infection related to indwelling catheter, DX: Neurogenic bladder. Intervention: keep tubing below the bladder and free of kinks or twists. Record review of Resident #181's physician order dated from December 2023 through April 2024 read in part . change Foley catheter with 18 inch catheter and 10cc bulb on the 1st of each month dated 12/22/23 and DC 02/06/24 . the resident has to go to a neurologist to get his foley catheter changed once a month FYI dated 02/06/24 . keep catheter from kinks and drainage bag lower than bladder at all times dated 12/22/24 . Bactrim DS tablet 800-160 mg 1 tablet x 7 days DX: urinary tract infection order date 01/27 24 - 02/03/24 . Bactrim DS tablet 800-160 mg 1 tab oral DX encounter for prophylactic measures dated 03/04/24 - 03/09/24 . During an observation on 04/18/24 at 2:35 p.m., Foley care was provided for Resident #181 [NAME] by CNA J and assisted by CAN R. CNA R used the same gloves from the beginning to the end of Foley care for Resident #181. CNA J donned gloves assisted Resident #181 to bed and took off his pants and incontinent brief. CNA J, still wearing the same glove, went and placed the brief in a trash can, and pushed the brief down inside the trash can. CNA J took the wipe packet from the top of the chest and placed it on the TV stand. CNA J, still wearing the same gloves, pulled wipes from the wipe packet, and provided Foley care for Resident#181, and he pulled wipes from the container seven times with the same dirty gloves. Resident #181 had his Foley catheter leg bag on while he lay down in bed, and the urine in the bag flowed backward toward the bladder, and the bag appeared flat. After CNA J provided care and Resident #181 sat on the edge of the bed, the urine started to flow downward. CNA J emptied the leg bag, and there was 250 ML of urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/24 at 2:50 p.m., Resident #181 was not able to state whether he wore a Foley catheter leg bag while in bed. During an interview on 04/18/24 at 2:58 p.m., CNA J said he did not change his gloves throughout the Foley care. CNA J said he used the same gloves and took wipes from the wipe packet, which caused cross-contamination. CNA J said Resident #181 always wore foley leg bag and he did not know why but the nurse would know. CNA J said he had in service on Foley care and infection control. During an interview on 04/18/24 at 3:09 p.m., Unit Manager L said when Resident #181 came to the facility, he had the Foley big bag and kept taking it off and putting it in the dresser. Unit manager L said Resident#181 went to the hospital in January on 01/28/23 and February 02/09/24 because he pulled the Foley catheter off. Unit Manager L said Resident #181 was better off with the leg bag, and she said the urine would not flow back to the bladder because the leg bag flows only one way. The unit manager said that even if the urine flowed back to the bladder, it was still better because Resident #181 removed the leg bag less than the big bag. Unit manager L said CNA J should have changed the use gloves before CNA J went into the wipe box. Unit manager L said it was an infection control: cross-contamination. During an interview on 04/18/24 at 5:16 p.m., Resident #181 provider said in his professional opinion, Resident #181 could go to bed with a Foley leg bag, and he had no problem. The provider said you should not be given anybody IJ because of the Foley bag, and he asked the surveyor to tell him what to write and that he would write the order. The provider said he could write the order for the leg bag to be hung below the bladder at night while Resident #181 slept to prevent the urine from flowing back into his bladder. During an interview on 04/18/24 at 5:48 p.m., RN A said Resident 181 had a Foley bag hung on the bed rail, but he always takes it out. RN A said about 2 to 3 weeks after he came to the facility, Resident #181 pulled the Foley out and was sent to the hospital. RN A said Resident #181 also takes the leg bag off because he knows how to disconnect it. RN A said the night Resident #181 came, he pulled the Foley out and was sent to the hospital. RN A said she could not remember which nurse called Resident #181's provider, and he gave the order to put Resident #181 on a foley leg bag. RN A said she did not know if Resident #181 was supposed to lie in bed with it because the urine could flow back to the bladder, which could cause infection. During an interview on 04/19/24 at 10:24 a.m., the DON said the Foley leg bag could flow back into Resident #181 just as the big bag if it was kept at the same level as the bladder. The DON said if the urine flowed back into Resident #181's bladder, it could cause UTI. The DON said the facility would instead go with the leg bag because the Resident pulls it off less than the big bag, and the unit manager would know more about it. The DON said CNA J should have changed his gloves before going from dirty to clean. The DON said CNA J contaminated the wipes in the packet. Record review of the facility policy on peri care dated 3/2006 A Right Reserved read in part . staff will provide cleanliness of genitalia to avoid skin breakdown and infection . for female/resident A#3 . separate labia to expose urethra meatus and virginal orifice . Record review of the facility policy on catheter /urinary catheter dated 07/2009 all Rights Reserved did not reveal placement of a foley catheter bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CDC.gov website CAUTI 104 (cdc.gov) read in part . Maintain the bag below the level of the bladder .