STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675915	A. Building B. Wing	01/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Care Center	121 Fm 971 Georgetown, TX 78626

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 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observations, interviews, and record reviews, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 2 (Resident #1 and Resident #2) of 2 residents reviewed for intravenous care. The facility failed to ensure Resident #1 had orders to change her PICC line dressing after the PICC was placed. She went from 12/18/24 until 01/09/25 without a PICC dressing change. The facility failed to ensure the ADON changed Resident #1's PICC line dressing per the facility protocol. The facility failed to ensure Resident #1 had orders to flush the PICC or to monitor the PICC insertion site for signs/symptoms of infection from 12/18/24 through 01/09/25. The facility failed to ensure Resident #2 had orders to flush the PICC or to monitor the PICC insertion site for signs/symptoms of infection from 11/13/24 through 11/27/24. The facility failed to ensure nursing staff (ADON, RN A, LVN B, LVN C, LVN D, and LVN E) were trained/educated on, and able to demonstrate competency on, managing a PICC line. The failures resulted in the identification of an Immediate Jeopardy (IJ) on 01/09/25 at 5:15 PM. While the IJ was removed on 01/11/25 at 4:10 PM, the facility remained at a level of no actual harm with potential for more than minimal harm that is not immediate jeopardy at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for decreased quality of care, not receiving intravenous medication as ordered, and risk for infection, hospitalization , and death. Findings included: 1.Review of Resident #1's face sheet printed on 01/09/25, reflected a [AGE] year-old female originally admitted to the facility on [DATE] with a recent readmission on 12/01/23. Her diagnoses included non-pressure chronic ulcer left lower leg, chronic venous hypertension, peripheral vascular disease, and cellulitis. (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 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section O (Special Treatments, Procedures, and Programs) reflected the resident received IV medications. Review of Resident #1's Order Recap Report for orders from 12/01/24 through 01/31/25, reflected orders dated 12/18/24: PICK [sic] LINE STAT one time only until 12/18/24, Piperacillin-Tazobactam 3.375 grams intravenously every 6 hours for infection for 28 days, ending 01/16/25, Vancomycin 1GM/250ml, use 1 gram intravenously one time a day for infection for 28 days, ending 01/16/25. Review of Resident #1's current Clinical Physician Orders, an order dated 01/09/25 reflected a revised Piperacillin-Tazobactam 3.375 grams intravenously every 6 hours for infection for 8 days, changed the end date to 01/17/25. Review of Resident #1's CVAD Procedure form, dated 12/18/24, reflected a PICC was inserted using ultrasound guidance on 12/18/24 at 7:30 PM. The catheter was trimmed and measured 38cm. The upper arm circumference was 31cm. Review of Resident #1's chest x-ray report dated 12/18/24, reflected the PICC terminated over expected level of the superior cavoatrial junction. Review of Resident #1's comprehensive care plan, on 01/09/25, last review completed 10/20/24, did not address the central line. Review of Resident #1's nursing progress note written 01/09/25 at 4:27 AM by LVN B reflected, Resident PICC line was clogged which made resident not able to receive 3:00 AM Piperacillin Sod-Tazobactam Sod Solution Reconstituted 3-0.375 GM IV. On call NP was notified, [company name] vascular was called but they were not picking up. Review of Resident #1's December 2024 MAR/TAR reflected the Vancomycin and Piperacillin-Tazobactam intravenous medications were both administered for 13 days. The MAR/TAR did not reflect any dressing changes, flushes, or monitoring of the site. Review of Resident #1's January 2025 MAR/TAR reflected a missed does of Piperacillin-Tazobactam on 01/09/25. The record reflected no monitoring of the central line site until 01/09/25, no flushing of the line until 01/09/25, and the first dressing and cap change scheduled for 01/10/25. During an observation and interview on 01/09/25 at 9:23 AM, Resident #1 was lying in bed with an IV infusing. She stated the IV was connected to the PICC in her arm. She stated she had asked several nurses to change the dressing because it was loose, but the dressing had not been changed since the PICC was inserted. When asked if there was a date on the dressing, she stated there was a date, but it was covered with tape, so it was no longer visible. Resident #1 attempted to adjust her sleeve to expose the dressing but could not do it without assistance. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 01/09/25 at 9:29 AM, RN A entered Resident #1's room and offered the resident assistance to visualize the PICC dressing. The PICC dressing was completely covered with white tape. The PICC insertion site was not visible. The edges of the dressing were not visible. Upon exiting the room, RN A stated this was the first PICC line she had worked with. She stated she had not been trained on changing the PICC dressing and did not feel comfortable attempting the procedure. She stated she had been shown how to flush the line and adjust the flow rate on the IV. She stated she had put some tape on the dressing to keep it in place until another nurse could change the dressing. She stated she had been trained on infection control and EBP. She stated not following infection control procedures could increase the spread of germs or infection. She stated she believed central line dressings were supposed to be changed daily and the IV tubing changed every 72 hours. During an observation and interview on 01/09/25 at 10:38 AM, the ADON sanitized an over the bed table and placed her dressing change supplies on the table and prepared to change Resident #1's PICC dressing. The ADON applied clean gloves and explained the procedure to the resident. She did not ask the resident to turn her head away from the insertion site. The ADON removed the dressing from the resident's arm. A bio patch (a small sponge-like wound dressing used to reduce local infections) coated with dry blood was attached to the dressing. The ADON removed the tape from the clear dressing. The dressing was dated 12/18/24. The ADON disposed of the old dressing and gloves then applied another pair of clean gloves. The resident repositioned her arm and viewed the site. The ADON opened the IV dressing change kit and retrieved the package of alcohol swabs. She used one swab to clean the insertion site and in a circular motion cleaned from the inside towards the outside. She continued to clean with the other two swabs in the package. The PICC line stabilization device that secured the line to the resident's arm was swabbed during the cleaning. The catheter line remained attached to the device and thus, the back of the line and the skin under the line was not cleansed. After the alcohol dried, the ADON took the clear dressing out of the dressing change kit and covered the insertion site and the stabilization device. She repositioned the resident then gathered her supplies. She did not change the caps. After exiting the room, the ADON stated she had training on central lines early in 2024. She stated some lady from the IV company came in and did a class for the nurses. She stated they did not get a competency or certificate from that training. During an interview on 01/09/25 at 1:26 PM, the ADON started to describe the procedure for changing a PICC dressing then stated, It's pretty much what you observed earlier. She stated there probably should have been orders for changing the dressing and the caps. Requested competencies/skills checks for central lines. During an interview on 01/10/25 at 3:57 PM, when asked is she should have followed sterile technique when changing Resident #1's PICC dressing, the ADON stated she thought she was changing the dressing on a peripheral IV and not a central line when she changed Resident #1's PICC dressing on 01/09/25. During a telephone interview on 01/09/25 at 1:52 PM, the NP stated Resident #1 was on IV antibiotics for osteomyelitis. He stated the wound care doctor had ordered the antibiotics. The NP stated he was sick and did not want to answer any other questions. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/09/25 at 3:07 PM, the MD stated he was the attending physician for Resident #1. He stated the staff informed him about the 12/18/24 date on Resident #1's PICC dressing. He stated it was an unfortunate miss. He stated he worked in infectious disease in a large hospital in [city] and he was aware of the major focus on preventing CLABSIs. He stated they rarely used PICCS or central lines at the facility, but the staff were very cautious when they did use them. He stated it was his expectation that the insertion site was monitored at least daily and assessed for redness, bleeding, and drainage. He expected the dressing to was monitored daily to ensure it was intact and sealed, and changed every 3 days. He stated the risk of infection increased if central lines were not properly maintained. 2. Review of Resident #2's face sheet, printed on 01/09/24, reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included diabetes mellitus, persistent vegetative state, hemiplegia following cerebral infarction, and pressure ulcers. Review of Resident #2's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected no BIMS score as resident was rarely/never understood. Staff assessment of her cognitive status reflected both short and long-term memory impairment. Review of Resident #2's order Summary Report for active orders as of 11/27/24, reflected the following orders: -Zosyn Intravenous Solution 3-0.375 GM/50ML use 3.375 gram intravenously for times a day for wound infection for 28 days, ordered 11/13/24. -Change PICC/Central line dressing Q3D one time a day every 7 day(s) for wound infection, ordered 11/14/24. -There were no orders to monitor the for s/s infection or to flush the central line. Review of Resident #2's Order Recap Report for all physician orders from 11/01/24 to 12/31/24, reflected an order, written 11/24/24, for Cath flow as directed one time only for clogged PICC line for 1 day. Review of Resident #2's CVAD Procedure form, dated 11/13/24, reflected a PICC was inserted using ultrasound guidance on 11/13/24 at 6:30 PM. The catheter was trimmed and measured 38cm. The upper arm circumference was 28cm. Review of Resident #2's chest x-ray report dated 11/13/24, reflected the PICC terminated in the region of the SVC. Review of Resident #2's November 2024 MAR/TAR reflected the Cath flow, was administered on 11/24/24 to unclog the PICC. The MAR/TAR reflected the PICC dressing changes were scheduled every 7 days. The dressing change was initialed as completed on 11/22/24. Review of Resident #2's SBAR, completed by LVN F, reflected Resident #1 transferred to an acute hospital on 11/27/24. Her temperature was 104.6 degrees Fahrenheit, and her pulse was 109. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's History and Physical Reports from the acute hospital, dated 11/27/24, reflected a chief complaint of fever. The admitting diagnoses included sepsis and pneumonia. Blood culture positive for Candidiasis, IV medication ordered. IV antibiotics were also initiated for pneumonia. During a brief interview on 01/09/25 at 9:40 AM, a policy for central lines and nurse competencies/skill checks were requested from the DON. During an interview on 01/09/25 at 2:32 PM, the DON stated she expected central lines to be cared for according to the policy. She described the dressing change process as, Apply clean gloves and remove the old dressing. Remove those gloves and perform hand hygiene. Apply sterile gloves. Clean 3 times with the alcohol and let it air dry. Apply the clear dressing and change the caps. She stated the dressing change kits were the same for peripheral IVs and central lines. She stated she expected the dressings and caps to be change weekly. She stated PICCs were flushed after each use, and periodically if the PICC was not used. She stated a PICC dressing dated 12/18/24 did not meet her expectations. She stated the dressings were clear, so the insertion site was visible, and they watched for any changes so there were no inherent risks from the dressing not being changed. She stated she was not aware that Resident #1's insertion site was covered with white tape. She stated that a covered dressing did not meet her expectations. The DON stated she was not sure if Resident #2 had orders to monitor or maintain her PICC line. The DON provided Nurse Skill Audits, but no competencies or skills checks specific to central lines. During an interview on 01/10/25 at 3:19 PM, RN G stated she had worked with Resident #2. She stated she did not remember the specific orders for the care and maintenance of her PICC line. She stated she remembered Resident #2 had a midline IV (an IV line, over 3 inches long, inserted in a large vein the arm upper and ends in the axilla or armpit) and not a PICC line. She stated the line became clogged but the IV company was able to get the line working again, so the line did not have to be replaced. Review of the Licensed Nurse Proficiency Audit, dated 11/16 (no year), for RN A reflected in part, 4. IV skills A. Initiating IV therapy N (needs improvement) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Nurse Proficiency Audit, dated 11/29 (no year), for the ADON reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Nurse Proficiency Audit, dated 07/31 (no year), for LVN B reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Nurse Proficiency Audit, dated 08/07 (no year), for nurse LVN C reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Licensed Nurse Proficiency Audit, dated 03/05/24 for LVN D, reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Licensed Nurse Proficiency Audit, dated 06/14 and 06/17 (no year) for LVN E, reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Care of Central Venous Catheter, Dressing Change policy dated 2003, reflected, Central venous catheters are used for long-term intravenous administrations. Invasive lines can also be used for a variety of care needs such as hyperalimentation and blood draws. The sites are high risk for infections and catheter care including dressing changes are performed to maintain sterility and prevent infection in central access catheters. Dressing changes are performed every 48 hours and prn if gauze is used or every week if transparent dressing is used. Sterile technique is used. Goals 1. The resident will be free from infection. 2. The resident will maintain skin integrity. Procedure 1. Explain the procedure and expected results to the resident. 2 Perform hand washing. 3 Create sterile field by opening glove wrapper. 4. Put on exam gloves. 5. Remove existing dressing using a no-touch technique. Discard dressing according to Universal Precautions. Remove exam gloves. 6 Perform hand hygiene. Apply sterile gloves. 7. Cleanse site with alcohol wipe x3. Let the site air dry. 8 Apply clear dressing. Label the new dressing with the date, time, and initials or label provided. Do not write on dressing, as ink will absorb through the dressing. 9. Lure lock injection caps will be changed as needed. 10. Clamp pigtail tubing. 11. Wear sterile gloves and prep pigtail cap connection with an alcohol swab. 12. Quickly twist off old cap and apply new cap. 13. Prepare top of cap with an alcohol swab. 14. Discard used supplies according to Universal Precautions. 15. Perform hand washing. 16. Document care and residents' response to treatment. Review of the Intravenous Medication Policy dated 2003, reflected in part, 1. The Physician may order any IV fluids and IV medications for resident in the nursing facility . 3. IV medication may be administered only by LVN or RN familiar with IV administration techniques . 8. Flush the IV according to physician's orders . Review of the Infection Control Plan: Overview, revised 03/2024, reflected in part, .II. Preventing infections related to the use of specific devices: Central venous catheters (CVCs) have also been associated with infectious complications. Other intravascular catheters such as dialysis catheters and implanted ports may be accessed multiple times per day, such as for hemodynamic measurements, or to obtain samples for laboratory analysis, thus increasing the risk of contamination and subsequent clinical infection. Limiting access to central venous catheters for only the primary purpose may help reduce the risk of infection. 1. Consistent use of appropriate infection control measures when caring for residents with vascular access catheters reduces the risk for catheter-related infections. 2. Surveillance consistently includes all residents with vascular access, including those with venous access and implanted ports such as peripherally inserted central catheter lines, and midline access catheters. 3. Activities to reduce infection risk includes surveillance such as observation of insertion sites, routine dressing changes, use of appropriate PPE and hand hygiene during the care and treatment of residents with venous catheters, and review of the resident for clinical evidence of infection. It is important that practices reflect the most current CDC guidelines. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM and DON were notified on 01/09/25 at 5:15 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 01/10/25 at 2:13 PM: 01/09/25 Plan of Removal On 0109/2025 an abbreviated survey was initiated at 10am. On 01/09/2025 the surveyor provided an Immediate Threat (IT) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. Problem: Central Venous Line Management Interventions: o DON completed 100% audit of current residents with central venous line on 1/9/2025 - no further issues identified (current resident in question). o The following in-services were initiated: 1. All nurses will be in-serviced on proper dressing change and care of a central venous line by the DON and/or Designee 2. All nurses will be in-serviced on infection prevention and monitoring for infection of a central venous line by the DON and/or Designee 3. All nurses will be in-serviced on receiving and validating central venous line management care with ordering physician by the DON and/or Designee 4. All nurses/agency nurses will not be allowed to begin work until they have received the above in-services/trainings by the DON and/or Designee - staff were able to verbalize comprehension post in-servicing. 5. DON in-serviced by compliance nurse 1/9/2025. - DON was able to verbalize comprehension post in-servicing. 6. Facility anticipates having this task completed by today, 1/10/2025. o The medical director was notified of the immediate jeopardy situation on 1/9/2025 at 7:00 pm Monitoring o The DON / designee will view each PICC/central venous line dressing 3xwk for 6 weeks and periodically thereafter to ensure compliance - it will be maintained on a monitoring log. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o The DON / designee will review Real time key word for any new orders for PICC/Central Venous Line 5 times a week for 6 weeks and periodically thereafter to ensure compliance it will be maintained on a monitoring log. o DON/Designee will validate all new orders of PICC/Central Venous Line 5 times a week for 6 weeks and periodically thereafter to ensure compliance it will be maintained on a monitoring log. o The QA committee will review findings and makes changes to the plan if needed. The investigators monitored the Plan of Removal on 01/10/25 and 10/11/25 as followed: During interviews conducted from 01/10/25 at 3:19 PM and 01/11/25 at 3:18 PM, 6 LVNs and 3 RNs from both shifts. 6 of the nurses stated they received in-service and had in-person training. 3 of the nurses stated they had received the training e-mail but had not been to the facility yet for the in-person training. They stated they would receive training prior to working their next shift. The nurses were able to speak to the central line dressing change procedure, infection control, and validating central venous line management care with the physician. The nurses stated the central line dressing and caps were changed every 7 days and prn if soiled or loose. The nurses stated the PICC site was monitored for signs and symptoms of infection and flushed as ordered. Review of the in-service given by the Regional RN on 01/09/25 to the DON, had the Care of Central Venous Catheter, Dressing Change policy attached. Review of a PICC in-service given by the DON, initiated on 01/09/25, reflected, Central line dressings must be changed at least weekly including cap change, and PRN, using sterile technique. The sign-in sheet contained 13 signatures. Review of a second PICC in-service given by the DON, initiated on 01/09/25, reflected, All residents with IVs of any type will have the order set for that IV type entered upon insertion, and site monitored for s/s complications at least every shift. The sign-in sheet contained 13 signatures. Review of the Nursing Scope in-service given by the DON, initiated on 01/09/25, reflected, if you as a nurse do not feel comfortable that you can safely perform a nursing task you must notify your supervisor immediately. We will either re-assign the task or teach it to you by doing it while you observe. You should never perform a skill you aren't confident in.[sic] The sign-in sheet contained 7 signatures. Review of the Clinicals in-service given by the DON, initiated on 01/09/25, reflected, all charge nurses who are working that day will be in the DON office every weekday at 9 AM for clinicals, no exceptions. The sign-in sheet contained 13 signatures. Review of the message sent by the ADM on 01/10/25 from 8:54 AM through 8:56 AM reflected 20 nurses were sent the message with the in-service trainings attached. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on interview and record review, the facility failed to ensure that licensed nurses were able to demonstrate the specific competencies and skill sets necessary to care for the resident's needs for 1 (Resident #1) of 1 resident provided care by 6 of 6 nurses (ADON, RN A, LVN B, LVN C, LVN D, and LVN E) reviewed nursing competency. The facility failed to ensure the ADON, RN A, LVN B, LVN C, LVN D, and LVN E who provided central line care and maintenance to Resident #1 from 12/18/24 through 01/09/25 were knowledgeable and competent on the facility's central line policy. These failures could place residents with central lines at risk of infection, line malfunction, hospitalization , and not receiving medication as ordered. Findings included: Review of Resident #1's face sheet printed on 01/09/25, reflected a [AGE] year-old female originally admitted to the facility on [DATE] with a recent readmission on 12/01/23. Her diagnoses included non-pressure chronic ulcer left lower leg, chronic venous hypertension, peripheral vascular disease, and cellulitis. Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section O (Special Treatments, Procedures, and Programs) reflected the resident received IV medications. Review of Resident #1's Order Recap Report for orders from 12/01/24 through 01/31/25, reflected orders dated 12/18/24: PICK [sic] LINE STAT one time only until 12/18/24, Piperacillin-Tazobactam 3.375 grams intravenously every 6 hours for infection for 28 days, ending 01/16/25, Vancomycin 1GM/250ml, use 1 gram intravenously give one time a day for infection for 28 days, ending 01/16/25. Review of Resident #1's current Clinical Physician Orders, an order dated 01/09/25 reflected a revised Piperacillin-Tazobactam 3.375 grams intravenously every 6 hours for infection for 8 days, changed the end date to 01/17/25. Review of Resident #1's CVAD Procedure form reflected a PICC was inserted using ultrasound guidance on 12/18/24 at 7:30 PM. The catheter was trimmed and measured 38cm. The upper arm circumference was 31cm. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's chest x-ray report dated 12/18/24, reflected the PICC terminated over expected level of the superior cavoatrial junction. Review of Resident #1's nursing progress note written 01/09/25 at 4:27 AM by LVN B reflected, Resident PICC line was clogged which made resident not able to receive 3:00 AM Piperacillin Sod-Tazobactam Sod Solution Reconstituted 3-0.375 GM IV. On call NP was notified, [company name] vascular was called but they were not picking up. Review of Resident #1's December 2024 MAR/TAR reflected the Vancomycin and Piperacillin-Tazobactam intravenous medications were both administered for 13 days. The MAR/TAR did not reflect any dressing changes, flushes, or monitoring of the site. The MAR/TAR reflected Piperacillin Sod-Tazobactam Sod Solution Reconstituted 3-0.375 GM IV was administered by LVN B on 01/01/25, 01/05/25, and 01/09/25, by LVN C on 01/03/25, 01/04/25, 01/05/25, and 01/06/25, by LVN D on 01/01/25, 01/02/25, 01/06/25, and 01/07/25, and by LVN E on 01/01/25, 01/02/25, 01/03/25, 01/06/25, 01/07/25, and 01/08/25. Review of Resident #1's January 2025 MAR/TAR reflected a missed does of Piperacillin-Tazobactam on 01/09/25. The record reflected no monitoring of the central line site until 01/09/25, no flushing of the line until 01/09/25, and the first dressing and cap change scheduled for 01/10/25. During an observation and interview on 01/09/25 at 9:23 AM, Resident #1 was lying in bed with an IV infusing. She stated the IV was connected to the PICC in her arm. She stated she had asked several nurses to change the dressing because it was loose, but the dressing had not been changed since the PICC was inserted. When asked if there was a date on the dressing, she stated there was a date, but it was covered with tape, so it was no longer visible. Resident #1 attempted to adjust her sleeve to expose the dressing but could not do it without assistance. During an observation and interview on 01/09/25 at 9:29 AM, RN A entered Resident #1's room and offered the resident assistance to visualize the PICC dressing. The PICC dressing was completely covered with white tape. The PICC insertion site was not visible. The edges of the dressing were not visible. Upon exiting the room, RN A stated this was the first PICC line she had worked with. She stated she had not been trained on changing the PICC dressing and did not feel comfortable attempting the procedure. She stated she had been shown how to flush the line and adjust the flow rate on the IV. She stated she had put some tape on the dressing to keep it in place until another nurse could change the dressing. She stated she believed central line dressings were supposed to be changed daily and the IV tubing changed every 72 hours. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/09/25 at 10:38 AM, the ADON sanitized an over the bed table and placed her dressing change supplies on the table and prepared to change Resident #1's PICC dressing. The ADON applied clean gloves and explained the procedure to the resident. The ADON removed the dressing from the resident's arm. A bio patch (a small sponge-like wound dressing used to reduce local infections) coated with dry blood was attached to the dressing. The ADON removed the tape from the clear dressing. The dressing was dated 12/18/24. No redness or drainage was noted at the insertion site. The ADON disposed of the old dressing and gloves then applied another pair of clean gloves. She opened the IV dressing change kit and retrieved the package of alcohol swabs. She used one swab to clean the insertion site and in a circular motion cleaned from the inside towards the outside. She continued to clean with the other two swabs in the package. The PICC line stabilization device that secured the line to the resident's arm was swabbed during the cleaning. The catheter line remained attached to the device and thus, the back of the line and the skin under the line was not cleansed. After the alcohol dried, the ADON took the clear dressing out of the dressing change kit and covered the insertion site and the stabilization device. She repositioned the resident then gathered her supplies. She did not change the caps. After exiting the room, the ADON stated she had training on central lines early in 2024. She stated some lady from the IV company came in and did a class for the nurses. She stated they did not get a competency or certificate from that training. The surveyor requested competencies/skills checks for Central Lines for the nurses. The ADON stated she would let the DON know about the request for the competencies. During an interview on 01/09/25 at 1:26 PM, the ADON started to describe the procedure for changing a PICC dressing then stated, It's pretty much what you observed earlier. She stated there probably should have been orders for changing the dressing and the caps. The surveyor requested competencies/skills checks for central lines. During an interview on 01/09/25 at 2:32 PM, the DON stated she expected central lines to be cared for according to the policy. She described the dressing change process as, Apply clean gloves and remove the old dressing. Remove those gloves and perform hand hygiene. Apply sterile gloves. Clean 3 times with the alcohol and let it air dry. Apply the clear dressing and change the caps. She stated the dressing change kits were the same for peripheral IVs and central lines. She stated she expected the dressings and caps to be change weekly. She stated PICCs were flushed after each use, and periodically if the PICC was not used. She stated a PICC dressing dated 12/18/24 did not meet her expectations. She stated the dressings were clear, so the insertion site was visible, and they watched for any changes so there were no inherent risks from the dressing not being changed. She stated she was not aware that Resident #1's insertion site was covered with white tape. She stated that a covered dressing did not meet her expectations. The DON provided Nurse Skill Audits, but no competencies or skills checks specific to central lines. During an interview on 01/09/25 at 3:07 PM, the MD stated it was his expectation that the insertion site was monitored at least daily and assessed for redness, bleeding, and drainage. He expected the dressing was monitored daily to ensure it was intact and sealed, and changed every 3 days. He stated the risk of infection increased if central lines were not properly maintained. During an interview on 01/10/25 at 3:57 PM, the ADON stated central line dressing changes were supposed to be sterile and a mask should have been worn during the procedure. She stated she thought she was changing the dressing on a peripheral IV and not a central line when she changed Resident #1's PICC dressing on 01/09/24. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/10/25 at 5:22 PM, the DON stated LVNs can perform central line dressing changes if they have had further training after completing nursing school. She stated LVNs could not insert or discontinue a central line nor draw blood through a central line. She stated there was an IV training class on their computer system that all nurses take upon hire and annually. She stated HR monitored the computer training and the clinical management monitored annual evaluation skill check offs. Review of Proficiency Audits for 5 licensed nurses who administered Resident #1's IV medications through the PICC line, and 1 licensed nurse who changed the PICC dressing with the following results. Review of the Licensed Nurse Proficiency Audit, dated 11/16 (no year), for RN A reflected in part, 4. IV skills A. Initiating IV therapy N (needs improvement) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Nurse Proficiency Audit, dated 11/29 (no year), for the ADON reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Nurse Proficiency Audit, dated 07/31 (no year), for LVN B reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Nurse Proficiency Audit, dated 08/07 (no year), for nurse LVN C reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Licensed Nurse Proficiency Audit, dated 03/05/24 for LVN D, reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the Licensed Nurse Proficiency Audit, dated 06/14 and 06/17 (no year) for nurse LVN E, reflected in part, 4. IV skills A. Initiating IV therapy S (satisfactory) B. Maintaining IV therapy S (satisfactory) C. Assessment S (satisfactory) D. Proper documentation S (satisfactory). No competencies or skills checks specific to central lines were provided. Review of the ADONs Certificate of Completion reflected she completed the course, Management of Intravenous Devices on 04/24/24 for 1 hour of training. A second Certificate of Completion reflected she completed Infusion Therapy: Central Lines on 01/09/25 for 0.13 of training hours (7.8 minutes). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care of Central Venous Catheter, Dressing Change policy dated 2003, reflected, Central venous catheters are used for long-term intravenous administrations. Invasive lines can also be used for a variety of care needs such as hyperalimentation and blood draws. The sites are high risk for infections and catheter care including dressing changes are performed to maintain sterility and prevent infection in central access catheters. Dressing changes are performed every 48 hours and prn if gauze is used or every week if transparent dressing is used. Sterile technique is used. Goals 1. The resident will be free from infection. 2. The resident will maintain skin integrity. Procedure 1. Explain the procedure and expected results to the resident. 2 Perform hand washing. 3 Create sterile field by opening glove wrapper. 4. Put on exam gloves. 5. Remove existing dressing using a no-touch technique. Discard dressing according to Universal Precautions. Remove exam gloves. 6 Perform hand hygiene. Apply sterile gloves. 7. Cleanse site with alcohol wipe x3. Let the site air dry. 8 Apply clear dressing. Label the new dressing with the date, time, and initials or label provided. Do not write on dressing, as ink will absorb through the dressing. 9. Lue lock injection caps will be changed as needed. 10. Clamp pigtail tubing. 11. Wear sterile gloves and prep pigtail cap connection with an alcohol swab. 12. Quickly twist off old cap and apply new cap. 13. Prepare top of cap with an alcohol swab. 14. Discard used supplies according to Universal Precautions. 15. Perform hand washing. 16. Document care and residents' response to treatment. Review of the Intravenous Medication Policy dated 2003, reflected in part, 1 3. IV medication may be administered only by LVN or RN familiar with IV administration techniques .