STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675934	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Dora Nursing and Rehabilitation Center	1960 Bedford Rd Bedford, TX 76021

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored in locked compartments for two of three medication carts (Nurse med carts #1 and #2) in that: LVN B left Nurse Med Cart #1 unlocked and unattended on 02/11/25 and on 02/12/25. LVN C left six medications on top of Nurse Med Cart #2 while the cart was unattended and out of the nurse's view on 02/12/25. These failures could place residents at risk of their medications being stolen or misused and health complications related to accidental ingestion of drugs and/or biologicals, including hospitalization . Findings included: During an observation and interview on the secure unit on 02/11/25 at 10:20 AM, it was revealed that LVN B left Nurse Med Cart #1 unlocked and unattended in the hallway against the wall by room A1 with the drawers facing out into the hallway. Nurse Med Cart #1 was unlocked with the drawers able to be opened and accessed. Multiple residents were seated in the dining room with the Nurse Med Cart#1 in view from the dining area. LVN B was observed walking back to the Nurse Med Cart#1 from inside one of the residents' rooms. The Nurse Med cart#1 contained insulins (medications that can lower blood sugars), prescription medications pills, over the counter medications, and breathing treatments inhalers containing albuterol, (a medication that causes nervousness, shakiness, throat/nasal irritation, muscle aches, and trembling). LVN B tapped her head and stated Ahh, I forgot to lock the cart. LVN B stated the expectation was the medication cart was always locked when no one was using it to prevent anyone without access to get into the med cart. During an observation and interview with LVN B on the secure unit on 02/12/25 at 07:50 AM it was revealed that the Nurse Med Cart #1 was unlocked, with drawers able to be opened and LVN B was out of view. LVN B was in the dining room away from the unlocked Nurse Med Cart#1. LVN B stated the medication cart should have been locked. She stated she forgot to lock it when not in use. LVN B stated the risk was a resident could get into the medication cart. (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
	675934	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Dora Nursing and Rehabilitation Center	1960 Bedford Rd Bedford, TX 76021

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/12/25 at 07:06 AM, revealed six medications were on top of Nurse Med Cart #2. The medications were left unattended. LVN C was inside room [ROOM NUMBER]. Multiple staff were observed in the hallway walking past the medication cart. The medications on top of the med cart were as follows: - Amlodipine tab 5 mg. Give 1 tablet by mouth 1 time daily *HOLD as Directed per MAR* (this medication is used to lower heart rate and blood pressure) - Carvedilol TAB 6.25 MG. Give 1 tablet by mouth 2 times a day. *HOLD as Directed per MAR* (this medication is used to lower heart rate and blood pressure) - Furosemide TAB 20 MG. Give 1 tablet by mouth 2 times a day (this is a diuretic a medication that helps to remove fluid from the body) - Jardiance TAB 10 MG. Give 1 tablet by mouth 1 time daily (Antidiabetic medication-this medication is used to control and lower blood sugar) - Losartan TAB 100-25. Give 1 tablet by mouth 1 time daily. *HOLD as Directed per MAR* (this medication is used to lower blood pressure) - Fluticasone Spray 50 MCG sub for Flonase. 1 spray in each nose (this medication is used for allergies) In an interview with LVN C on 02/12/25 at 07:26 AM, she stated she should have locked the medications inside the medication cart. She stated she forgot and was nervous being watched. LVN C stated that any resident could have come to the cart and picked up the medications. During an interview on 02/13/25 at 1:36 PM, the DON stated the expectation was all the medication carts were locked when not in use and unattended to decrease the risk of residents and unauthorized persons getting into the cart and accessing medications. Record review of the facility's policy titled Storage of Medications, with a revision date of April 2007, reflected, in part, The medication cart shall be secured during medication passes ., when it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall and drawers facing the wall. The cart must be locked before the nurse enters the room . medications carts must be securely locked at all times when out of the nurses view

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675934	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Dora Nursing and Rehabilitation Center	1960 Bedford Rd Bedford, TX 76021

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 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. 44894 Based on observation, interview, and record review the facility failed to store, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure food items in the refrigerator were dated, labeled, and sealed appropriately. The failure could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observations of the facility's kitchen refrigerator on 02/11/2025 at 9:00 AM revealed the following items were not sealed, labeled, or dated with any dates: 1 plastic bag with 7 hardboiled eggs not labeled or dated. 1 large container of hot sauce almost empty not dated. 1 open container exposed to air in refrigerator with bell peppers and onion not sealed , labeled, or dated. Observations of the facility's kitchen freezer on 02/11/2025 at 9:15 AM revealed the following items were not sealed, labeled, or dated: 1 box of frozen beef patties not dated. Interview with the Dietary Manager on 02/12/2025 at 10:45 AM revealed that all food is to be sealed, labeled, and dated. The dietary department received an order on Monday, 02/10/2025. The [NAME] was responsible for labeling and dating the frozen food in the freezers and backstock foods in the pantry. The Dietary Aides were responsible for labeling and dating the food in the refrigerators and stocking the disposable goods. The Dietary Manager revealed that staff had been trained on labeling and dating. The Dietary Manager would in-service staff on sealing, labeling, and dating. Review of facility Food Storage Policy, dated 2001 and last revised on 11/2022, revealed All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675934	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Dora Nursing and Rehabilitation Center	1960 Bedford Rd Bedford, TX 76021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control measure designed to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident #44 and Resident #106) reviewed for infection control in that: 1. LVN A failed to sanitize her hands after moving Resident #44's floor mat before touching his bedside table and did she not change her gloves after touching the door, adjusting the bed and touching the privacy curtain before touching Resident #44's G-tube. 2.LVN A, CNA D, and CNA E failed to prevent cross contamination of Resident #44's care items during wound care. 3. LVN C failed to sanitize the stethoscope (this is a medical device used for listening to internal sounds in the body) that was on her neck covered with hair before placing it on Resident #106 stomach to listen to his bowel sounds and g-tube placement. These deficient practices could place residents at risk of transmission of communicable diseases and infections. Findings include: 1. Review of Resident #44's face sheet dated 02/11/25 revealed a [AGE] year-old male who admitted at the facility on 02/21/23 with a primary diagnoses of anoxic brain damage (this is brain damage caused by lack of oxygen). His secondary diagnoses were dementia (this is a brain disease that alters brain function and causes a cognitive decline) , pneumonia, need for assistance with personal care, Heart diseases and heart failure, difficulty speaking and swallowing, gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing), Chronic Peripheral Venous Insufficiency (this is a condition that occurs when veins in the legs or arms have difficulty returning blood to the heart), and high blood pressure. Review of Resident #44's quarterly MDS assessment dated [DATE] revealed a Brief Inventory of Mental Status (a standardized assessment to measure long and short-term memory) of zero out of fifteen, indicating severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675934	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Dora Nursing and Rehabilitation Center	1960 Bedford Rd Bedford, TX 76021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #44 care plan initiated 08/08/24 revealed Resident #44 had a right popliteal fossa wound (wound behind the knee). The goal was Resident#44 would be free from infection or complications related to arterial ulcer (this is a painful wound caused by poor blood circulation in the lower legs) through review. The interventions were Analgesia (pain medication) as ordered. Monitor/document side effects and effectiveness, Honey alginate, calcium alginate with dry dressing, monitor/document wound: size, depth, margins: peri wound skin, sinuses, undermining, exudates (leaks), edema (swelling), granulation pink or red soft tissue healing process) , infection, necrosis, eschar (black tissue), gangrene (green drainage and Foul odor). Document progress in wound healing on an ongoing basis. Notify physician as indicated; Monitor/document/report PRN any s/sx of infection: green drainage, foul odor, redness and swelling, red lines coming from the wound, excessive pain, and fever. The care plan further revealed a focus Resident #44 had a peripheral artery disease ulcer (this is a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) of the right calf and the left calf r/t Peripheral Arterial Disease. The goal was Resident #44 would be free from infection or complications related to arterial ulcer through review date. The interventions included analgesia as ordered. Monitor/document side effects and effectiveness, apply thin layer of iodoform to gauze, place on the open wound cover with dry dressing, change daily and PRN. Observation on 02/11/25 at 12:15 PM, revealed LVN A walking into Resident #44's room. She stood on the floor mat beside Resident #44 as she told him that she was going to give him his medications. After talking with Resident #44, LVN A stepped off the floor mat and rolled it to the side with her bare hands. LVN A then went to Resident #44's table that contained medications cups, a g-tube syringe and cylinder and moved the table. LVN A did not sanitize her hands before touching the bedside table. LVN A then stated she would go and wash her hands. She went to Resident #44's bathroom, opened the door and washed her hands. When she came back, she put on gloves then she stated she needed water for the g-tube and she went back to the bathroom with the cylinder and opened the door with her gloved hands. She returned and placed the water on the bedside table. She then adjusted Resident #44's bed with a remote, removed his covers to expose the g-tube and touched Resident #44's g-tube. LVN A did not change her gloves after touching the bathroom door, adjusting the bed and moving the bed covers before touching Resident #44's g-tube. In an interview with LVN A on 02/11/25 at 12:34 PM, she stated she had contaminated the resident's table by not performing hand hygiene after moving the floor mat. She stated she was nervous being watched and forgot to change her gloves before g-tube medication administration. LVN A stated she had been in serviced on g-tube management and medication administration prior to her taking care of the residents with g-tube. She stated hand hygiene was expected for infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675934	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Dora Nursing and Rehabilitation Center	1960 Bedford Rd Bedford, TX 76021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation and interview with LVN A on 02/12/24 at 10:50 AM, revealed LVN A placed wax paper on a bedside table. On top of the wax paper, she placed wound care items for Resident #44 which contained gauze pieces, large pieces of band aids, wound cleanser, and wound ointment. LVN A placed the bedside table next to the privacy curtain and the bedside table was placed to where it was touching the privacy curtain . The curtain was touching the wax paper with the items on it. CNA D and CNA E came into the room to assist LVN A. CNA D and CNA E reached over the bedside table containing the wound care items to get to the side table where they kept gowns for PPE. Both CNA D and CNA E dressed into their PPE standing right next to the wound care items for Resident #44, their gowns touched the wound care items. CNA E was observed handing LVN A a gown directly over the bedside table with the wound care items. CNA E placed the gown on top of the bedside table with the wound items for LVN A. LVN A then reached over the bedside table with the wound items to get into the side table to get a gown, but CNA E stopped her and pointed to the one that she had set on the bedside table on top of wound care items for her. Further observation revealed LVN A was cleaning Resident #44's wound, CNA E reached over from the left side of LVN A to help hold Resident #44's foot. CNA E was diagonally over the cleaned wound as LVN A dressed the wound underneath CNA E outstretched arms. There was no barrier between the Resident #106's leg and the mattress, CNA E was holding leg off the mattress. LVN A stated she should have kept the wound care field clean and not allow anyone access to it. She stated the wound care table was a clean field and no one should reach over it, and she stated she should not have left the wound care items exposed by many staff before use. She stated it was a standard precaution to keep supplies clean for infection control. In an interview with CNA D on 02/12/25 at 11:30 AM, she stated she had been in serviced by DON about enhanced barrier precautions and that PPE must be worn for residents with wounds. CNA D stated she did not know to put on PPE away from wound care items. She stated she had been trained on the importance of Infection control. In an interview with CNA E on 02/13/25 at 1:20 PM, she stated she did not know that she could not reach over a clean field and could contaminate the supplies. She stated she was not thinking well when she reached over to hold Resident #44's foot up. 3. Review of Resident #106's face sheet dated 02/13/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His primary diagnosis was benign neoplasm of cerebral meninges. His secondary diagnosis was disseminated Zoster (shingle virus), chronic atrial fibrillation (this is a heart condition that causes an irregular, often rapid heart rate that can cause poor blood flow), gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing), and kidney failure. Review of Resident #106 admission MDS dated [DATE] revealed it was in process and not completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675934	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Dora Nursing and Rehabilitation Center	1960 Bedford Rd Bedford, TX 76021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #106's care plan initiated on 02/07/25 revealed as a gastrostomy tube will remain patent (open) and intact through next review. Gastrostomy site will remain free from s/s of infection through next review. The interventions were to apply clean dressing to gastrostomy site daily, clean g-tube site daily and prn, Flush gastrostomy tube as directed to keep patent, monitor gastrostomy stoma for s/sx of infection, e.g., reddens, excessive drainage, foul odor, pain. The care plan also revealed Resident #106 was at risk for secondary infection due to the active shingle virus. The goal was the resident would remain hydrated and show no signs and/or symptoms of infection., The interventions were to educate the resident/representative on techniques to prevent infection, such as handwashing, adequate rest, nutrition, and avoidance of crowds, Evaluate for source of infection. Observation on 02/13/25 at 07:29 AM, revealed LVN C at Resident #106's bedside. LVN C removed the stethoscope that was around her neck and in between her braided hair and placed it on Resident #106's stomach next to his g-tube. LVN C did not sanitize the stethoscope before use on Resident #106. After LVN C was done she put the stethoscope back on her neck and then onto the medication cart. LVN C did not sanitize the stethoscope after use and before placing it on top of the medication cart. In an interview with LVN C on 02/13/25 at 07:53 AM, she stated she forgot to sanitize the stethoscope before use, and she should have cleaned it after use. She stated she forgot, and she could have contaminated the resident and herself. She stated shared equipment was sanitized to prevent infection. In an interview with the DON on 02/13/25 at 1:36 PM, she stated all staff were expected to use standard infection control precautions including hand hygiene wherever it was applicable. She stated can E was being helpful to hold the foot during wound care, but she should not be reaching over wound, and she should not be reaching over the clean field with the wound care items. The DON stated nurses back in her days were trained to have their hair tied back or to wear hair cover so that the stethoscope was not covered by hair. She stated the expectation was for LVN C to sanitize the stethoscope before use and after use. She stated, She should have cleaned, clean stethoscope for infection control. The DON stated she had in-serviced on infection control including EBP. The DON said she was responsible for monitoring that infection control precautions were being followed. Review of the facility's policy dated December 2023, and titled Standard Precautions revealed .Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status .hand hygiene is performed with soap (anti-microbial or non-antimicrobial) or alcohol-based hand rub before and after contact with the resident .Resident-Care Equipment: reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed . Review of Facility's policy titled Wound Care, revision date October 2010 reflected the following, read in part, . 1.Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675934	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Dora Nursing and Rehabilitation Center	1960 Bedford Rd Bedford, TX 76021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 7. Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. 8. Pour liquid solutions directly on gauze sponges on their papers. 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 11. Place one (1) gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply to dressing. Be certain all clean items are on clean field Review of the policy Skin Management dated 2001 revealed the following: Residents having pressure injuries receive the necessary care and services to promote healing, prevent infection . Appropriate measures to promote healing and prevent infection will be provided . Review of the facility's Treatment Nurse Competency Check Off, undated, revealed the following: 6. Gather all needed supplies for treatment, including piece of wax paper/barrier for over bed table, and set up items maintaining clean field. 21. If any area was contaminated, start over.