STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675942	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towers Nursing Home	372 Hill Road Smithville, TX 78957

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633 Based on record review and interviews the facility failed to complete preadmission screening for a resident with a mental disorder. The facility failed to review and correct a PASSR evaluation for Resident #45 . This failure could result in the resident not receiving correct and approved treatments, medications and quality of life enhancements. Findings include: Review of the Face Sheet for Resident #85 reflected she was admitted on [DATE] with diagnosis of: Myocardial Infarction, Dementia, and bipolar Disorder unspecified. Review of the entry MDS for Resident #85 dated 5/17/24 reflected no cognitive assessment, a 00 BIMS score. Her physical assessment reflected she needed assistance or supervision with all ADL's, she ambulated via wheelchair and walker. She was assessed as having an indwelling catheter. She was assessed as frequently incontinent of bowel and bladder. Review of the Care Plan for Resident #85 reflected interventions were in place for: ADL performance deficit, Impaired cognitive function, High risk for falls, Psychotropic medications, Indwelling catheter for urinary retention, impaired visual function. In an interview on 6/05/24 at 2:25 PM the MDS nurse stated the facility had received an incorrect PASSR for Resident #85 on admission (5/13/24) and was submitting a Form 1012 to have it corrected (not completed on 6/05/24). The MDS nurse stated Resident #85's primary diagnosis should be changed from Myocardial Infarction to Dementia. She stated the change might be made if or when she was changed to long term care. The MDS nurse stated it had been approximately two weeks since Resident #85's admission and the physician should have signed it by now. The MDS nurse stated it was her responsibility to check the PASSER forms were accurate. In an interview on 6/06/24 at 10:20 am LVN M stated Resident #85 had not displayed any manic or depressive behaviors in her time at the facility. She stated daily monitoring for behaviors was ordered. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/06/24 at 10:35 am LVN P stated she had observed Resident #85 daily since she was admitted . She stated Resident #85 liked to sit with other residents and was normally quiet and calm. In an interview on 6/06/24 at 11:00 am the DON stated Resident #85 had arrived with an incorrect PASSR evaluation and the facility should have corrected it immediately. She stated it was not known if Resident #85 would be staying long term and there was no way to know if her primary diagnosis could be changed to Dementia. She stated Resident #85 was diagnosed with Bipolar. In an interview on 6/06/24 at 11:40 am the administrator stated the facility policy was not followed for Resident #85. The administrator stated the PASSR for Resident #85 was incorrect and should have been resubmitted for correction. He stated the MDS normally reviews and refers to the source of the assessment when a correction was needed. He stated the correction for the diagnosis of Bipolar disorder unspecified should have been clarified, such as Bipolar Depressive or Bipolar Manic. The administrator stated the facility followed state guidelines to complete and submit PASSR evaluations.

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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** 49855 Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for 1 of 8 residents, in that: Resident 29 was not provided fingernail care. This failure affected one resident and could place her at risk of infection and diminished self-esteem. Findings include: Record review of resident's 29 face sheet reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of: type 2 diabetes with diabetic neuropathy, dementia, hypertension, hypokalemia, overactive bladder, atrial fibrillation, hypothyroidism, gastro esophageal reflux disease, restless leg syndrome, and osteoarthritis. Record review of the quarterly minimum data set (MDS) assessment for resident 29 dated 04/25/24 reflected a brief interview for mental status (BIMS) score of 00 indicating impaired cognitive function. Her physical assessment for functional abilities and goals reflected she required supervision for eating, maximum assistance for all other ADLs, always incontinent of bladder, and frequently incontinent of bowel. Record review of the care plan for resident 29 dated 04/25/2024 reflected she had an ADL self-care performance for personal hygiene deficit related to impaired cognition, muscle weakness, pain, and lack of coordination. Interventions: Requires extensive assistance by one staff with personal hygiene. Care plan reflected resident was at risk for signs or symptoms of covid 19 and an intervention included assisting resident in practicing hand hygiene. Note: Care plan reflected resident 29 is resistive to care at times. No documentation reflected or staff interviews stated resident 29 refused personal hygiene or nail care. Care plan did not address resident 29 digging in brief with her hands. Record review of resident 29 medication administration record (MAR) and TAR (treatment administration record) reflected no records of nail care being provided. Record review of task list for resident 29 in point click care (PCC) reflected nail care is scheduled to be provided by CNA on days. Record review of order summary for resident 29 did not reflect any order for nail care. Observation on 6/04/2024 at 10:22 am revealed resident 29 seated in her wheelchair in the dining room drinking coffee with other residents. Resident 29 had her hands placed under the table. Surveyor asked resident 29 if she could show her hands to surveyor. Resident 29 lifted her hands up and resident 29 was observed with a brown substance under her nails of both hands. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/05/2024 at 2:54pm revealed resident 29 resting in bed and her fingernails had a brown substance under nails of both hands. Observation on 06/06/24 at 9:45 am revealed resident 29 seated in her wheelchair in the hallway outside of her room with brown substance under nails of both hands. In an interview on 06/06/24 at 9:20am with LVN D she stated direct care staff know what kind of care residents need based on their kardex and care plan. She stated nail care is the CNA's and nurses' responsibility. She stated if a resident is diabetic the nurses do nail care. She stated resident 29 does not refuse nail care and the reason her nails get dirty is because resident 29 scratches at her pants and also digs her fingers into her brief. In an interview on 06/06/24 at 9:36am with CNA G he stated staff know what kind of care a resident need based on their kardex, information passed during report or shift change, common sense, and will ask nurse or therapy. He stated resident 29 tends to dig her fingernails into her brief. He stated CNAs are responsible for fingernail care but not toenails if a resident is diabetic. He stated nail care is done on Sundays. In an interview on 06/06/24 at 10:20am with DON, she stated staff know what care residents need by looking at the kardex and pocket care plans especially for staff that have moved to another hall. She stated they try and not use the pocket care plans. She stated the facility has a lead CNA that floats and two CNA instructors in building. She stated everyone is responsible for nail care. She stated resident 29 scratches and digs at her brief and they clean her nails throughout the day. She stated resident 29 needs nail care throughout the day because she has periods of diarrhea. In an interview on 06/06/24 1240pm with ADM he stated staff refer to a resident's kardex or pocket care plan to find out about a resident's ADLs. He stated staff are also given education and in-services. ADM stated he does role play for in services where he is the resident, and they practice and train for ADLs. He stated he tells staff do not be afraid to ask for help because this protects the resident and staff as well from injury. He stated he tells staff it is better go up in care instead of going down. For example, if a resident is a one person assist and a staff member feels they cannot provide aid by themselves to ask for help. He stated nurses take care of nail care for residents who are diabetic and if the resident is not diabetic the CNAs provide nail care. He stated nails are trimmed as needed. Review of facility policy dated 05/26/2023 titled Activities of Daily Living reflected the following: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of in-services for 2023 and 2024 revealed there were no in-services about nail care.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314 Based on interview, observation, and record review the facility failed to ensure that the residents environment remained as free of accident hazards as was possible for one (Resident #45) of thirty-three residents reviewed for hazards. The facility failed to ensure that Resident #45 was assisted by two care providers during peri-care resulting in her rolling out of the bed onto the floor and sustaining facial lacerations. This failure could place residents at risk of accidents and injury. Findings Include: Review of Resident #45's Face Sheet dated 06/05/2024 reflected an [AGE] year-old female admitted to the facility on [DATE] with the following diagnosis: Cerebral Infarction (result of disrupted blood flow to the brain due to problems with the blood vessels that supply it resulting in lack of oxygen and vital nutrients which CAN cause parts of the brain to die off), Parkinson (brain conditions that cause slowed movements, rigidity (stiffness) and tremors), and Morbid (Severe) Obesity (complex chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions). Review of Resident #45's MDS Admission Assessment, dated 05/09/2024 revealed Resident #45 had a BIMS Score of 15, which indicates cognition is intact. Resident #45's MDS revealed in Section GG - Functional Abilities and Goals - Admission A. Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed indicated 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity , or the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident #45's Comprehensive Care Plan revealed a problem area [Resident #45] has an ADL self-care performance deficit r/t muscle weakness, contracture, pain and decreased mobility Date Initiated: 05/02/2024 with an intervention for BED MOBILITY: [Resident #45 requires total assist by 2 staff to turn and reposition in bed as necessary. Date Initiated: 05/13/2024. Review of Occupational Therapy OT evaluation & Plan of Treatment, start of care date 05/03/2024 revealed, Resident #45 Assessment Summary: Clinical impressions: Resident #45 presents with multiple impairments that have contributed to decline in independence with functional ADLs and safety that will be addressed by skilled OT services in order to facilitate pt return to PLOF. Impairments include: decreased strength and flexibility, impaired coordination, activity tolerance, balance reactions, and decreased Independence with ADLs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Transfer Related Incident Report, prepared by RN A, dated 05/10/2024 at 12:00 PM. Resident #45 was found after fall lying on the floor parallel to her bed, lying face down, hollering and crying. Description: Complete head to toe skin assessment. NVS initiated. Wound care provided. PRN pain medication administered. Physician notified. Orders to send to ER for evaluation and treatment if indicated. Resident taken to Hospital? Y. Witnesses: CNA H, Relation: Staff, Date 5/10/2024, Statement: I was changing resident, resident was capable of talking to this CNA, helping this CNA and acknowledged that she knew what she need to do during peri care. This CNA asked resident, CAN you please turn your body to the right? resident said, Yes, I will help as much as I can. Then this CNA said, CAN you allow yourself to go to the side of the bed to hold on the edge of the bed? and resident said, Yes. As she held on to the edge of the bed, she proceeded to put more force with her own body, and that allowed her to tip more weight to her right side, allowing her to go from the bed to the floor. Resident was on floor parallel to her bed, face down, and then nurse was notified to come to resident's room. Notes: 5/10/2024 Resident sent to hospital for x-rays returned with no acute injuries, education provided to staff that she is a 2 person assist with all aspects of care. Review of [Medical Facility Emergency Department Record dated 5/10/24 revealed, Patient Complaint: Facial Lacerations, Triage Assessment: Facial Lacerations. Review of [Medical Facility] Emergency Physician Record dated 5/10/2024 revealed, Adult Injury lac to nose. Review of facility's progress notes in their electronic records system for Resident #45 revealed the following: 5/10/2024 19:30 (7:30 PM) NURSING - Nurse Note Late Entry (unidentified staff): Note Text: resident brought to room per wheelchair per two staff members. Transferred to bed. was awake and able to make needs known. v/s 96.4 t, 20r, 96o2 at room air, 70 hr., 138/74. Status post injury to face and bruising to left hand. Stated some pain to face. Call light within reach, bed on low. 5/11/2024 17:03 (5:03 PM) NURSING - Nurse Note Text (unidentified staff): S/P witnessed fall day 1, resident with small steri-strips to nose and small band aid to upper lip CDI, mentation at baseline, up per normal routine, currently sitting in wheelchair in main dining room for dinner, resident taking Ibuprofen prn for pain and is effective. 5/11/2024 20:32 (8:32 PM) NURSING Nurse Note Text (unidentified staff): 2nd day status post fall. resident lying in bed and awake. able to answer questions appropriately at this time. v/s: 96.2 forehead, 18r, 93O2 sat on RA, 67 hr., 116/64. face continues with steri-strips to bridge of nose and band aid to upper lip. is able to make needs known. call light within reach, bed on low. 5/13/2024 19:51 (7:51 PM) NURSING - Nurse Note Text (unidentified staff): resident had a fall out of bed on 05/10/24 which she ended up in the ER for evaluation for trauma to face. resident does c/o pain to face. resident requested ibuprofen 400mg, which was effective. she is a 2-person assist with transfers and changes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 06/05/2024 at 8:09 AM, Resident #45 was observed lying in her bed and had some discoloration under both of her eyes, which appeared to be diminishing. Resident #45 stated that approximately one month ago she requested that an add assist her with peri-care. Resident #45 stated a CNA assisted her and as she started to roll her to her side she was not able to stop her momentum and rolled off the bed onto the floor. Resident #45 stated when she fell it caused bruising to her face. Resident #45 stated the CNA was provided the care by herself and that her rolling off the bed was an accident. Resident #45 was observed to be heavy set and did not appear to have much core strength or the ability to assist with her care. Interview on 06/05/2024 at 3:19 PM, RN A stated she was at work on 5/10/24, when Resident #45 fell from her bed. RN A stated she was at the nurse's station when CNA G came and told her that Resident #45 had fallen. RN A stated that when she entered the room of Resident #45 she observed CNA G and CNA H present and believed the bed was in the low position. RN A stated she observed Resident #45 on the floor between her bed and the wall and observed she was bleeding and possibly injured in the area of her nose and eyes. RN A stated she did a full assessment of Resident #45, who stated she was alright. RN A stated she then used the mechanical lift with the assistance of the CNAs to place Resident #45 back in her bed. RN A stated she notified the DON, Administrator, RP, and both ADONs were present. RN A stated after assessment and contact with NP, Resident #45 was sent to the emergency room due to contact with her head and face to ensure no head trauma or fractures. RN A stated she spoke with and obtained a statement from CNA H, who told her Resident #45 asked to help her clean up (peri-care). RN A stated CNA H told her she was rolling Resident #45 to her side by herself, and she just continued to roll over and out of the bed. RN A stated she would assume Resident #45 was a 2 person assist for bed mobility / peri-care due to her weight. RN A stated in her opinion if peri-care was being performed on Resident #45 she should have been assisted by 2 CNAs. Interview on 06/05/2024 at 3:30 PM, CNA H was contacted by phone and stated that she was at work. CNA H stated she could not speak due to being in the presence of patients and would call back at approximately 5:30 PM when she left work. Interview on 06/05/2024 at 3:44 PM, CNA G stated he was at work on 05/10/2024 and was in the area of Resident #54 when he heard what he described as desperate screaming. CNA G stated he entered the room of Resident #45 and saw CNA H standing by the bed with a look of shock on her face. CNA G stated he saw Resident #45 on the floor on the other side of her bed and observed that she was bleeding. CNA G stated he asked CNA H what happened, and she did not respond. CNA G stated he went quickly and got RN A to come to the room. CNA G stated he moved Resident #45's bed out of the way and stated he believed it was in the mid position, which would be standard for peri-care. CNA G stated RN A assessed Resident #45 and then they placed her back in the bed using a mechanical lift to do so. CNA G stated he heard RN A ask CNA H what happened, and she told her she was trying to change Resident #45 and she rolled out of the bed. CNA G stated he worked 7 AM to 1 PM on the day of the fall and left shortly after but did see EMS arrive and knew the AIT was on location. CNA G stated when he returned to work after the fall that Resident #45 was back in the facility. CNA G stated he and all staff were trained and instructed that Resident #45 was to be a 2 person assist for all care and transfers. CNA G stated he had never attempted peri-care on Resident #45 by himself prior to or after the fall and did not know of anyone other than CNA H during this incident who had. CNA G stated common sense should have been enough for CNA H to know that she should not have attempted peri-care on Resident #45 by herself. CNA G stated he does not believe CNA H wanted this to occur and is a very caring person. CNA G stated he knew after the incident that CNA H was removed from the hallway and did not provide further care for Resident #45. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/05/2024 at 4:09 PM, ADON B stated she was in the facility on 05/10/2024, when Resident #45 fell out of the bed. ADON B stated she was notified of Resident #45's fall from the bed and went to the room. ADON B stated CNA H stated she was providing peri-care for Resident #45 and when she rolled her on her side she continued to roll and fell off the bed. ADON B stated it was not appropriate for CNA H to have been performing peri-car on Resident #45 without assistance. ADON B stated Resident #45 had blood coming from her mouth and nose and was transported by EMS. ADON B stated after Resident #45's fall they trained all staff on 2-person transfers / assist and ensured that staff knew that Resident #45 was a 2-person assist. Interview on 06/05/2024 at 4:33 PM, the DON stated she was not in the facility on 05/10/2024 but was notified by the Administrator of Resident #45's fall. The DON stated after the incident all staff were in-serviced that Resident #45 was a 2-person assist with all care. The DON stated she went and spoke to Resident #45 after the fall, and she stated she felt safe in the facility. The DON stated she knew Resident #45 was a 2-person assist after this incident but was unsure if that was the case prior due to her limited time in the facility before the fall. At 4:49 PM, the DON stated she checked the records and that Resident #45 was in fact a two person transfer at the time of the fall and that CNA H should not have been provided peri-care on Resident #45 by herself. Interview attempted on 06/05/2024 at 7:04 PM with CNA H, who had not called as she stated she would. CNA H did not answer, and the call was sent to voicemail. Follow-up interview on 06/06/2024 at 8:03 AM, CNA G stated they are trained to review the kardex before providing care to ensure patients' needs are bed and proper assistance is provided. CNA G stated if they ever go to another hallway to assist they CNA look at the kardex but are also informed verbally of assist requirements by the CNAs regularly assigned to the hall. CNA G stated during the in-service they were instructed that Resident #45 was to be a 2-person full assist and that they received specialized training to include interactive participation and demonstration. CNA G stated during the in-service training they were also instructed on proper brief size for residents during peri-care. CNA G stated since Resident #45's fall and the staff in-service that he has never seen or heard of anyone attempting care on Resident #45 by themselves and does not believe Resident #45 would allow them to do so if they did try. Interview on 06/06/2024 at 8:15 AM, the Administrator stated Resident #45 was sent to the emergency roiagnom on the day of the fall for a CT-Scan to rule out any bleeds / fractures, or any other injuries received during the fall. The Administrator stated no treatments were required and that the fall resulted in bruising to the area of both eyes and her nose. The Administrator stated he was working to obtain her medical records to provide as confirmation of no further injuries. Interview on 06/06/2024 at 8:50 AM, the AIT stated he was in the facility on 05/10/2024 when Resident #45 fell from her bed. The AIT stated he spoke by phone with the Administrator and notified him of Resident #45's fall. The AIT stated he met with Resident #45 after the fall, and she stated she felt safe in the facility. The AIT stated he never spoke directly with CNA H about the incident. The AIT stated he could not state whether it was appropriate for CNA H to have performed 1-person peri-care due to his current limited role as a trainee in the facility and the matter being handled by the Administrator. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/06/2024 at 9:20 AM, the Therapy Director stated Resident #45 would obviously need 2-person assistance because she requires mechanical lift. Therapy Director stated due to Resident #45's size and lack of truck control there should not be less than two assisting her with bed mobility / peri-care. Therapy Director stated in his professional opinion CNA H should not have attempted peri-care on Resident #45 by herself. Interview on 06/06/2024 at 9:40 AM, the ADON stated she was in the facility on 05/10/2024 when Resident #45 fell . The ADON stated she went to Resident #45's room after notification and observed that Resident #45 was back in her bed. The ADON stated she observed blood on the floor by Resident #45's bed and observed she was bleeding from her nose and mouth. The ADON stated she told RN A to contact the Administrator and physician. The ADON stated Resident #45 need to be sent to the emergency room for a CT-Scan due to contact with her head and to ensure she had no other injuries. The ADON stated CNA H should not have performed peri-care on Resident #45 by herself. The ADON stated after the fall they immediately put interventions in place to prevent further occurrences. The ADON stated all staff were in-serviced that Resident #45 was a 2-person total care. The ADON stated Resident #45 was changed to a bariatric bed, which was wider to minimize risk of recurrence. The ADON stated when she spoke with Resident #45 after the fall that she told her that it was an accident. The ADON described CNA H as approximately five foot seven and one hundred and sixty pounds. The ADON stated CNA H walked out during a shift approximately two weeks after this incident and was no longer in the facility. Interview on 06/06/2024 at 9:56 AM, CNA I stated she was new to the facility and was currently on her second day of training in the 300 hallway. CNA I stated the facility trained their CNA staff by each individual hallway before being assigned to ensure they know the residents and their needs. CNA I stated she has been trained to review the kardex to ensure proper care and assistance is provided to residents. CNA I stated assistance for peri-care was provided under the continence tab. CNA I stated in addition to the electronic files she was walked down the 300 hallway by staff on the first day and verbally advised of each residents level of assistance with bed mobility and transfer. CNA I stated she has been trained and believed that even if a resident was indicated for 1-person assist that she would only provide the care by herself if she was sure that she could safety and correctly do so. CNA I stated they have to consider everything from how heavy the resident was, to their fragility. CNA I stated failure to ensure adequate assistance with task for residents could result in injury. Follow-up interview on 06/06/2024 at 3:00 PM, Resident #45 was seated in her wheelchair in the lobby. Resident #45 stated she had always had care provided by at least two staff members prior to his incident. Resident #45 stated since her fall she has never had care provided by less than two staff members. Resident #45 stated the injury to her mouth must have occurred when she accidentally bit herself during the fall. Resident #45 stated she did not believe this was an intentional act and stated she loves it at this facility and does not believe anything like this would ever happen again. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/06/2024 at 3:08 PM, the Administrator stated he investigated the fall during peri-care involving Resident #45 and CNA H. The Administrator stated staff were in-serviced on transfers and ensured that all knew Resident #45 was a 2-person assist. The Administrator stated he interviewed Resident #45 after the fall and she indicated to him that this was an accident that took place during care. The Administrator stated Resident #45 was upset because she did not like that CNA H did not stop her from falling and then did not immediately react after her fall. The Administrator stated he interviewed Resident #45 a second time and she again indicated that this incident was an accident that occurred during her peri-care. The Administrator stated during peri-care / transfers that it is his expectation that, a resident is never put in a situation that could cause harm. Review of Imaging Services Report from [Medical Facility] with an indicated film date of 5/10/2024 revealed, Impression: No acute infarction, hemorrhage, or mass effect. Review of personal / training file for CNA H revealed, Restorative Nursing Assistant Competencies Checklist, Areas of Skill 3. Bowel & Bladder 11/06/2023 Pass, 6. Bed Mobility 11/06/2023 Pass. Candidate Clinical Card for CNA H indicated initials by Pericare F and Pos on side. Review of Form 5497 Texas Nurse Aide Performance Record revealed Section VII, Personal Care Perineal Care / Incontinent Care - Female (With or Without Catheter), Classroom / Online 10/23/23, Skill Lab 11/28/2023, Clinical 11/20/2023. Certificate of Completion from [Nursing Facility] to CNA H in recognition of completion of the requirements for [Nursing Facility] Nurse Aide Training Program #TX44989 completed on 12/06/2023. The facility did provide documentation of all mandatory background checks within the past calendar year. Review of undated [Nursing Facility] In-Service Training Report for All Staff, Topic [Resident #45], Summary of Training Session: Resident is a 2 person care at all times with all aspects of care. Review of the facility's Activities of Daily Living (ADLs) policy dated 05/26/2023 revealed, Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 2. Transfer and ambulation; Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49851 Based on observation, interview, and record review the facility failed to administer parenteral fluids consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for Resident #6. The facility failed to assess and properly label Resident #6's peripheral intravenous catheter (PIV) This failure could place residents at risk of infection, infiltration, and not receiving appropriate PIV care. Findings include: Review of Resident #6's Face Sheet reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included unspecified dementia, acquired absence of left leg above knee, atherosclerosis (a buildup of fats, cholesterol, and other substances in and on the artery walls), anemia (low levels of healthy red blood cells to carry oxygen throughout the body) and chronic pain. Review of Resident #6's MDS Assessment, dated 05/09/2024, reflected a BIMS score of 14 which indicted her cognitive function as intact. Review of Resident #6's Comprehensive Care Plan reflected IV therapy was not addressed. The care plan reflected the resident was at risk for infection and fluid volume deficit. Observation on 06/04/2024 at 09:45 AM revealed Resident #6 lying in bed with a PIV to her right wrist. A clear dressing was in place over IV site with tape to secure dressing and IV tubing. An empty bag of normal saline was connected to the IV. No date, initials or IV gauge (size) noted on the dressing. Observation on 06/04/2024 at 11:25 AM revealed Resident #6 sleeping. The IV tubing had been disconnected from the IV and discarded. Observation on 06/05/2024 at 10:00 AM revealed right wrist PIV still in place. Dressing intact with no label. In an interview on 06/05/2024 at 11:40 AM, LVN E stated peripheral IV maintenance should be done every shift to include cleaning the site, flushing to ensure patency and applying dressing with date and initials. She stated she was not sure if the current dressing for Resident #6 was dated or initialed. She stated not properly labeling the IV could put the resident at risk for infection. Observation on 06/06/2024 at 08:20 AM revealed Resident #6 sitting in bed. Right wrist PIV has been removed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/06/2024 at 09:15 AM, LVN F stated the standard of practice for IV insertion and care would be to date and initial the IV dressing after insertion. He stated if it was not dated, then staff would not know when it was started or if it was changed. In an interview on 06/06/2024 at 09:50 AM the DON stated her expectation for IV care would be for the site to be dated, initialed, checked every shift and PRN. She stated the site should be discontinued if not needed. If it needs to stay in, she expected an order in place. She would expect the site to be checked by the nurse on each shift and was upset to find out that was not happening for Resident #6. Review of facility policy for IV catheter insertion and care, dated July 2016, reflected all IVs should be labeled to include the date and time of catheter insertion, initials, length and gauge of catheter on the label.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice for 2 (Resident #65 and Resident #81) of 8 residents reviewed for respiratory care. A) The facility failed to ensure that Resident #65's oxygen tubing with nasal cannula was changed out every seven days. The facility failed to ensure that Resident #65's Nebulizer tubing and mask, which included the nebulizing chamber (unit into which liquid medicine is converted into aerosol or mist by the pressurized air pumped through the tubing), was replaced every seven (7) days and bagged. The facility further failed to ensure that the air filter on Resident #65's air concentrator filter was free of dust and debris. B) The facility failed to ensure that Resident #81's oxygen tubing and nasal cannula was changed out every seven days and failed to date the tubing and failed to ensure that Resident #81's air concentrator filter was free of dust and debris. These failures could place residents at risk for respiratory compromise and infection. Findings Included: A) Review of Resident #65's Face Sheet dated 06/05/2024 reflected an [AGE] year-old female admitted to the facility on [DATE] with the following diagnosis: Unspecified Dementia, Moderate (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from disease of the brain), Chronic Respiratory Failure with Hypoxia (condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and Heart Failure (heart does not pump enough blood for your body's needs). Review of Resident #65's MDS Quarterly Assessment, dated 03/06/2024 revealed Resident #65 had a BIMS Score of 12, which indicated moderate cognitive impairment. Resident #65's MDS indicated for Respiratory Treatments that she was under C1. Oxygen therapy and further indicated under Section I that she had active diagnosis for Pulmonary (relating to lungs). Review of Resident #65's Comprehensive Care Plan revealed [Resident #65] has potential for ineffective breathing pattern and air way clearance related to chronic lung disease with respiratory failure with an intervention for OXYGEN as ordered with revision date of 03/30/2023. Review of Resident 65's Order Summary Report dated 06/05/2024 reflected the following start dates / orders: 06/20/2023 for Oxygen 2L NC prn sats<92% and 05/23/2024 for Ipratropium-Albuterol Inhalation Solution0.5-2.5 (3) MG/3ML(Ipratropium-Albuterol) 1 vial inhale orally every 8 hours for SOB/Wheezing. Further review revealed Resident #65's orders did not reflect any order in reference to care of her oxygen tubing or equipment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/04/2024 at 8:31 AM, Resident #65 was in her bed receiving oxygen via nasal cannula from an oxygen concentrator at 2L. The tubing was dated in fine print at the connection point with the concentrator which either displayed 5-21-24 or 5-26-24, both of which would have been past the seventh day. The air filter on the back of the concentrator was found to be dirty with built-up particles stuck to it. There was a nebulizer present on the nightstand to the side of Resident #65's bed that had oxygen tubing connected to it that lead to a mask with an in line nebulizing chamber. The mask was exposed to the air, not bagged, resting on paperwork, and was dated 5-26-24. Interview and observation on 06/04/2024 at 1:47 PM, Resident #65 was in her bed receiving oxygen via nasal cannula. Resident #65's nebulizer mask was now in a plastic bag on the nightstand and the outside of the bag was dated 6/4/24. The mask inside the bag was the same mask dated 5-26-24 that was observed earlier and had not been changed. Resident #65's oxygen tubing at the port of the concentrator now displayed a date of 5-28-24 and it was obvious that the 21 or 26 had been wrote over to place the 28 on the tubing. Resident #65 stated that a staff member did come in her room after the initial observation but stated that no one changed out her tubing / nasal cannula and that she was using the same one she had at 8:31 A. M. Resident #65 had a trash can beside her bed that had a dirty air filter in it and the concentrator now had no filter on the back of it. B) Review of Resident #81's Face Sheet dated 06/05/2024 reflected an [AGE] year-old female admitted to the facility on [DATE] with the following diagnosis: Unspecified Dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from disease of the brain), Chronic Respiratory Failure with Hypoxia (condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and Heart Failure (heart does not pump enough blood for your body's needs). Review of Resident #81's MDS Quarterly Assessment, dated 04/19/2024 revealed Resident #81 had a BIMS Score of 7, which indicated severe cognitive impairment. Resident #81's MDS indicated for Respiratory Treatments that she was under C1. Oxygen therapy and further indicated under Section I that she had active diagnoses for Pulmonary (relating to lungs). Review of Resident #81's Comprehensive Care Plan revealed a problem area [Resident #81] has oxygen therapy r/t chronic respiratory failure with an intervention for OXYGEN SETTINGS: O2 via NC @ 2LPM continuously with revision date of 05/03/2024. Review of Resident #81's Consolidated Orders last reviewed on 05/21/2024 reflected the following start date / order: 04/14/2024 for Oxygen at 2 LPM via NC. Resident #81's orders did not reflect any order in reference to care of her oxygen tubing or equipment. Observation on 06/04/2024 at 8:12 A.M, Resident #81 was in her bed receiving oxygen via nasal cannula from at concentrator at 2.75 L. Observed that the tubing from the concentrator to her cannula had no date displayed anywhere. The air filter on the back of the concentrator was found to be dirty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 06/04/2024 at 2:18 PM, Resident #81 was in her bed receiving oxygen via nasal cannula from a concentrator. Resident #81's concentrator now had a plastic bag attached to it with her name and a date of 6/4/24. Resident #81's oxygen tubing now had a date present on it at the port for the concentrator, which displayed 6/3/24. The filter on the back of the concentrator was found to still be dirty and unchanged. Resident #81 stated a nurse did come in earlier, but that they did not change out her oxygen tubing / nasal cannula that had been in use. Interview and observation on 06/06/2024 at 11:19 AM, LVN D stated respiratory tubing and mask are to be changed out every seven days and dated. LVN D stated they normally place an orange identification sticker on the tubing, which they were to record the date and time of change on. LVN D stated the nebulizer mask was also to be changed every seven days and have the date recorded on them. LVN D started the concentrator filters are to be cleaned weekly and all oxygen mask and Cannulas are to be in a dated bag when not in use. LVN D stated all oxygen checks / changes are to be performed by the night nurse every Sunday. LVN D stated no one should ever record a date on top of another date because the tubing should be replaced, and a new date recorded. LVN D stated their procedures for oxygen equipment needed to be followed for infection control and to prevent respiratory infections. At 11:24 AM, LVN D entered the room of Resident #65, who was receiving oxygen via nasal cannula. LVN D checked the respiratory equipment for Resident #65 and stated nebulizer mask was past date and should not have been placed in a plastic bag with today's date. LVN D stated a new mask and tubing should have been installed and today's date placed on it before being placed in the bag. LVN D stated the date on the oxygen tubing at Resident #65's concentrator had been recorded over and that whoever did so should not have and should have replaced the tubing with cannula and recorded the new date. At 11:27 AM, LVN D entered the room of Resident #81, who was receiving oxygen via nasal cannula. LVN D checked the respiratory equipment for Resident #81 and stated it was not correct. LVN D stated if the oxygen tubing in fact was changed out on 6/3/24 as recorded that the bag on the concentrator should display the same date. LVN D stated the filter on the concentrator appeared to not have been cleaned in the past seven days. Interview on 06/06/2024 at 11:50 AM, the DON stated all respiratory tubing needed to be changed and dated every seven days. The DON stated respiratory equipment like mask and Cannulas should be bagged when not in use by the residents. The DON stated a date should never be recorded over and that to do so would not be their standard practice and could result in respiratory issues for the resident. The DON stated all respiratory tubing, mask, and Cannulas are to be changed every Wednesday but that she does allow staff until Sunday if it was not more than seven days. The DON observed evidence obtained in reference to Resident #65 and Resident #81's respiratory equipment and stated it was not within policy, should not have been done, and could lead to a respiratory infection for the resident. Interview on 06/06/2024 at 12:05 PM, the Administrator stated his expectation was for oxygen tubing / equipment to be replaced and dated every seven days or when soiled if less than seven days, stored in a bag at bedside when not in use, and replaced anytime it was found on the floor. The Administrator stated all oxygen tubing / equipment in to be replaced by a nurse every Wednesday night and that failure to do so could result in the resident having an adverse effect. The Administrator was requested to provide their policy in reference to oxygen equipment / care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Oxygen Safety policy dated 01/26/2024, reflected, Policy: It is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. Further review revealed that he provided policy did not address respiratory care equipment in reference to dating and change of oxygen tubing, mask, cannulas, bagging of respiratory equipment when not in use, or cleaning of concentrator filters.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen reviewed for sanitation. The facility failed to date a box of bananas in the dry storage area which contained a banana that was open and rotted. The facility failed to ensure that no food products or food product boxes were stored on the floor in the facility's walk-in refrigerator and freezer. The facility failed to ensure that a food product in the freezer was in a sealed bag to prevent direct exposure to air. The facility failed to discard of food products that were past indicated use by dates per facility policy. These failures could place residents at risk of cross contamination, loss of nutritional value, and foodborne illness. Findings included: Observation on [DATE] at 6:25 AM, of the facility's walk-in refrigerator revealed the following: *a bag of lettuce on the floor, *1 metal tray covered in plastic wrap that was labeled, Cake [DATE] to [DATE], *1 covered metal container marked ground beef [DATE] 10:00 AM use by [DATE], *1 sealable plastic bag with hot dog [NAME] in it that only had a date of [DATE], and *one 16-ounce container of strawberries on the shelf of which one strawberry had visible signs of mold growth on it. Observation on [DATE] at 6:33 AM, of the facility's walk-in freezer revealed the following: *two boxes of mild Italian pork sausage on the floor, with boxes stacked on top of them. * an open box of biscuit dough on a shelf that had an open bag allowing direct air exposure in the freezer to the product. Observation on [DATE] at 6:38 AM, of the facility dry storage area revealed an undated open box of bananas, one of which was busted open and rotten. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and observation on [DATE] at 10:45 AM, the FSS stated that all items placed in the refrigerator should have the date they are placed in it and then a use by date of no more than four days. The FSS stated in the dry storage area she expected items to be labeled, clearly identified, and date with the received-on date. The FSS stated failure to date food products could result in a lack of knowledge for how long the product has been in the kitchen. The FSS stated no food products or boxes should be stored at any time on the floor of the dry storage area, or the walk-in refrigerator / freezer. The FSS stated storage of food products on the floor could result in possible contamination. The FSS conducted a walk through and stated she discarded the bag of lettuce that was on the floor in the refrigerator due to possible contamination. The FSS stated the boxes found in the freeze should not have been on the floor and were placed more than six inches off the floor. The FSS had discarded all the food product was past the use by date in the refrigerator except for the plastic bag of hot dog [NAME]. The FSS stated they should not have been on the shelf and added there should have been a use by date recorded on the bag. The FSS stated failure to removed expired / out of date food products could result in food borne illness. Interview on [DATE] at 11:03 AM, DA stated all food products should be dated as soon as they are received. DA stated once opened and placed in the refrigerator they are supposed to record the date opened and then a use by date for three days later when placed in the refrigerator. DA stated failure to label and date items could result in expired food being served leading to possible foodborne illnesses. DA stated no food products should be stored on the floor anywhere in the kitchen to prevent contamination. DA stated items that are placed in the freezer are to be in sealed bags our bags that are tied closed to prevent air exposure. DA stated exposed food products in the freeze could lead to freeze burn resulting in poor taste and loss of nutritional value. Follow-up interview on [DATE] at 11:08 AM, the FSS stated service of expired food products could lead to contamination and sickness for residents. The FSS stated food exposed in the freezer could result in freezer burn affecting the quality of the food and taste. The FSS stated all staff should be checking for quality and expiration dates but ultimately the responsibility falls on her to ensure that nothing is out of stated or stored improperly. Interview on [DATE] at 11:12 AM, the Administrator stated his expectation was for all food products to be labeled, dated, and removed from the refrigerator within seventy-two hours if not used. The Administrator stated no food products should be stored on the floor and should always be at least six inches off the ground. The Administrator stated failure to follow these guidelines could lead to bacteria and contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Food Storage Policy dated [DATE] reflected, Policy: The consultant dietitian will monitor the storage of foods to ensure that all food served by the facility is of good quality and safe for consumption. All food will be stored according to the state and Federal Food Codes. The following guidelines should be followed. Guidelines: 1. Dry Storage rooms d. To ensure freshness, opened and bulk items are stored in tightly covered containers. All containers are labeled and dated. f. Where possible, items are left in the original cartons placed with the date visible. 2. Refrigerators a. All refrigerated foods are stored per state and federal guidelines. b. Fresh meat, poultry, seafood, dairy products and most fresh fruit and vegetable are kept in the refrigerator at an internal temperature <41 F. c. All food is stored on racks or shelves off the floor. e. All refrigerated foods are dated, labeled and tightly sealed, including left overs, using clean, nonabsorbent, covered containers that are approved for food storage. All leftovers are used within 72 hours. Items that are over 72 hours old are discarded. 3. Freezers c. All foods are stored on racks or shelves off the floor. e. Frozen foods are stored in moisture-proof wrap or containers that are labeled and dated. Review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that CNA be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE]. 11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633 Based on interview and record review the facility failed to establish an infection prevention and control program that must include, at a minimum, an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 2 (Residents #94 and Resident #28) of 3 residents reviewed for infection control A) The facility failed to follow the antibiotic stewardship recommendations for Resident #94. B) The facility failed to follow the antibiotic stewardship recommendations for Resident #28 This deficient practice could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use and increased antibiotic-resistant infections. Findings include: A) Review of Resident #94's Face Sheet reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses include chronic systolic (congestive) heart failure, anemia (low levels of healthy red blood cells to carry oxygen throughout the body), hyperlipidemia (high levels of fat particles in the blood), depression, anxiety, chronic pain, retention of urine, muscle spasms. Review of Resident #94's MDS Assessment, dated 03/29/2024, reflected a BIMS score of 09 which indicated moderate cognitive impairment. Review of Resident #94's Comprehensive Care Plan reflected resident was on antibiotic therapy related to Urinary Tract Infection (UTI) prophylaxis, initiated 03/26/2024. Interventions included Administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness every shift. Monitor/document/report PRN adverse reactions to antibiotic therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat). Monitor/document/report PRN signs/symptoms of secondary infection r//t antibiotic therapy: oral thrush (white coating in mouth, tongue), persistent diarrhea, and vaginitis/itchy perineum/whitish discharge/coating of the vulva/anus. Review of Resident #94 orders, written by NP K, start date of 3/26/2024 for cephalexin oral 250mg with an end date of indefinite. The order reflected an indication for use as UTI prophylaxis. Review of Resident #94's Medication Administration Record for the months of March, April, May and June of 2024 reflected she has received cephalexin 250mg daily at 0900 (9:00AM) starting on 03/26/2024. Review of the Antimicrobial Stewardship Recommendation for Resident #94, dated 03/28/2024, reflected a recommendation by the consultant pharmacist to amend the cephalexin order to include an end date and states the prophylactic use of anti-microbials was contra-indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675942	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towers Nursing Home	372 Hill Road Smithville, TX 78957

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Consultant Pharmacist's Medication Regimen Review for Resident #94, dated 03/28/2024, reflected a recommendation by the consultant pharmacist to amend the cephalexin order to include an end date and states the prophylactic use of anti-microbials is contra-indicated. In an interview on 06/06/24 11:00 AM the DON stated the use of antibiotics for UTI prophylaxis was not acceptable and she has spoken with the providers regarding this practice. She stated it was an ongoing issue that has been addressed before and she will continue to communicate with the providers regarding this. She stated the potential consequence of over prescribing could be development of antibiotic resistance and superbugs. B) Review of Resident #28's face sheet reflected a [AGE] year-old female admitted to the facility 08/16/2022 with the following diagnoses dementia(A group of symptoms that affects memory, thinking and interferes with daily life.), osteoporosis (A condition when bone strength weakens and is susceptible to fracture. It usually affects hip, wrist, or spine.) and Hypertension (High pressure in the arteries (vessels that carry blood from the heart to the rest of the body). Symptoms varies from person to person and generally include unexplained fatigue and headache.). Review of Resident #28's Quarterly MDS dated [DATE] reflected Resident #28 was assessed to have a 00 BIMS score indicating severe cognitive impairment. Resident #28 was assessed to require substantial/ maximal assistance with all ADLs. Resident #28 was assessed to be incontinent of bladder. Resident #28 was assessed to not be on antibiotics during the assessment period or to have a UTI in the past 30 days. Review of Resident #28's comprehensive care plan reflected a problem dated 08/16/2022 and revised on 04/25/2024 Resident #28 always has bladder incontinence r/t decreased mobility, muscle weakness, HX of UTI and impaired cognition. Interventions included Monitor/document for signs and symptoms of UTI: pain, burning, blood-tinged urine, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Review of Resident #28's nursing progress notes reflected an entry dated 5/30/2024 Caregiver requesting UA, states resident was not acting herself. New order for UTI panel/reflex received. Review of Resident #28's nursing progress notes reflected an entry dated 05/31/2024 indicating Rocephin 1 gm was administered IM after urine was collected. Review of Resident #28's urinalysis and UTI panel dated 06/05/2024 reflected Resident #28's UA C&S was negative for infection. In an interview on 06/06/2024 at 10:00 AM the DON stated the nurses called Resident #28's physician and got orders for the UA C&S. The DON stated Resident #28 should not have been given antibiotics prior to her lab results coming back. She stated she has been having trouble with the physicians not following the antibiotic stewardship policies of the facility. The DON further stated the residents should not be placed on antibiotics unless the PCR test comes back and the resident has a high bacterial load. (continued on next page)

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	675942	A. Building B. Wing	06/06/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a statement dated 05/03/2020 from the facility's Medical Director reflected .As discussed in multiple previous mandatory provider meetings, most recently last month April 2024, has recommended all providers consider getting UpToDate to help with keeping up with the latest guidelines along with the use of policies, procedures, and medical director recommendations. Antibiotic stewardship is of optimal importance in order to collaboratively maintain and align processes for assessing, planning, evaluating, and implementing evidence-based and patient centered antimicrobial stewardship practices, including new drugs, patient care strategies, policies and procedures, treatment guidelines, systems and processes, and antimicrobial stewardship practices integrated into the community. As always, we should all follow evidence-based practice and use all your resources to make the best decision for our patients. To support your stewardship practice, we will work on incorporation and consistency methods to include antibiogram, resident and family information materials, and Loeb and McGeer Criteria for initiation of antibiotics in long-term care residents. Review of the facility's policy Antibiotic Stewardship Program dated 10/24/2022 reflected It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use .a. Antibiotic use protocols: 1.Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR form prior to notifying the physician. Laboratory testing shall be in accordance with current standards of practice. The facility uses the updated McGeer criteria to define infections. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized .Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents, and families . 32452 49851