| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676042 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| McAllen Transitional Care Center | 2109 South K St<br>MC Allen, TX 78503 |

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) |
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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487<br><br>Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for 1 of 1 resident (Resident#66) reviewed for indwelling catheters.<br><br>The facility failed to prevent Resident#66's urinary catheter bag/tubing from touching the floor.<br><br>This failure could place residents at risk for cross contamination and urinary tract infections.<br><br>Findings included:<br><br>Record review of Resident#66's face sheet dated 12/12/24 revealed a [AGE] year-old male originally admitted on [DATE]. Resident#66 had primary/admitting diagnoses of Anemia, Unspecified (a condition where the number of red blood cells is below normal, but the type or cause of the anemia is not specified), and Neurogenic bladder (a condition that affects bladder control due to damage to the nervous system).<br><br>Record review of Resident #66's MDS dated [DATE], Section C-Cognitive patterns revealed Resident #66 did not had a BIMS score indicated. Section H- Bladder and bowel revealed Resident #66 had not had an indwelling catheter.<br><br>Record review of Resident #66's care plan dated 3/13/24 revealed Resident #66 had a Foley catheter Neurogenic Bladder Date initiated 11/22/24 and revised on 11/22/24 Intervention/tasks listed Provide catheter care every shift and Position catheter bag and tubing below the level of the bladder and away from entrance room door initiated and revised on 11/22/24.<br><br>Record review of the Order Summary of Resident's #66 order printed 12/20/24 revealed order to Change Foley Catheter French 20 with 30 milliliters balloon every month and if accidental removal, dislodgement or obstruction as needed. Order Foley catheter check every shift and as needed start dated 11/22/24.<br><br>During an observation on 12/10/24 at 10:32 AM, revealed Resident #66 Foley catheter bag was noted lying on the floor under Resident #66's bed. Resident #66 was non interviewable.<br><br>(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 |
|---|---|---|

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with CNA C on 12/10/24 at 10:40 AM, CNA C was informed and shown the catheter bag laying on the floor. She said that she noted that the privacy bag that was attached to the bed was torn. She stated that she checked earlier around 9:00 AM and the Foley catheter bag was not touching the floor at that time. CNA C stated if Resident's #66 foley bag was on the floor, the bag could get contaminated, and the resident could get an infection. CNA C said that she would replace the privacy bag for a new one and would put the foley catheter bag inside it. CNA C said that the last in-service on foley catheters and infection control was done last week.<br><br>During an interview with CNA A on 12/11/24 at 1:05 PM CNA A said that it was important for the bag not to touch the floor because the resident could be at risk for getting an infection. CNA A said that if bag was on the floor staff could step on it. CNA A said that the last in-service on infection control was last week but could not recall the exact date.<br><br>During an interview with CNA B on 12/11/24 at 1:10 PM CNA B said she checked the Foley bags on residents every time she went into the resident's room. CNA B said it was important to keep foley bags in the privacy bags to prevent the bags touching the floor because the resident could get an infection. CNA B said that the last in-service on infection control was last week.<br><br>During an interview with CNA D on 12/12/24 at 9:30 AM CNA D said that the Foley bags should be on the sides inside the privacy bag that was attached to the bed. CNA D said that if the foley bag was in the floor, someone could step on it. CNA D said that foley bag was not supposed to be on the floor because the resident could be at risk of getting an infection.<br><br>During an interview with LVN E on 12/12/24 at 1:40 PM LVN E said that Foley bags should be below the bladder level and the foley bag inside a privacy bag. LVN E said that the foley bags should not be on the floor because the bag could tear, and the resident could get an infection. LVN E said that the last in-service on infection control was last month.<br><br>During an interview with RN F on 12/12/24 at 2:15 PM RN F said she checks during her shift that was placed correctly and not touching the floor. RN F stated that foley bag should never be touching the floor because it could get pinched, or it could cause a leakage if the foley bag was on the floor. RN F said that the last in-service on infection control was yesterday.<br><br>During an interview with the ADON on 12/12/24 at 3:05 PM the ADON said that nurses were in charge on checking the Foley bags every shift and that managers made rounds every morning. The ADON said that she educated staff to make sure everything complied. The ADON said that the bag should not be touching the floor to prevent any infections. The ADON said that the last in-service was last Friday, 12/6/2024.<br><br>During an interview with the DON on 12/12/24 at 3:10 PM the DON said all staff were responsible to check that the Foley catheters had a privacy bag. The DON said that he provided 3 privacy bags for each resident that had a foley catheter. He said that 2 bags were attached to the bed and the third one was attached to wheelchair or walker depending on each resident needs. The DON said that if a foley bag was touching the floor, the bag could get contaminated and could introduce and infection or bag could get a leak. The DON said that the last in-service was last week.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record Review of a policy titled, Infection Prevention and Control Program with revision and review date 12/2023, reflected, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. Goal is to decrease the risk of infection to residents and personnel.<br><br>Record Review of a policy titled, Catheter Drainage Bag with the revision and review dated 12/2023, reflected, Position the drainage bag below the level of the resident's bladder and without resting on the floor. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487<br><br>Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 residents (Resident's #234) reviewed for respiratory care.<br><br>1. The facility failed to ensure Resident #234's oxygen was placed on 2 liters per minute via nasal cannula as ordered by the physician.<br><br>These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care.<br><br>Finding included:<br><br>1.Record review of Resident #234's face sheet, dated 12/10/24 indicated she was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease also known as COPD, (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).<br><br>Record review of Resident #234's quarterly MDS assessment was in process.<br><br>Record review of Resident #234's physician's order dated 12/6/24 indicated Oxygen at 2 liters per minute continuous via nasal cannula every shift for COPD.<br><br>Record review of Resident #234's comprehensive care plan, dated 12/06/24, indicates Resident #234 required oxygen therapy related to ineffective gas exchange. The intervention of the care plan was for staff to give medications as ordered by physician. Monitor/document side effects and effectiveness.<br><br>During an observation on 12/10/24 at 9:23 a.m., Resident #234 was lying in her bed with oxygen set at 2.5 liters per minute via nasal cannula.<br><br>During an observation on 12/12/24 at 9:35 am Resident #234 was lying in her bed with oxygen set at 2 liters per minute via nasal cannula.<br><br>During an interview on 12/10/24 at 2:40 p.m., LVN G looked at Resident #234's oxygen rate and said it was at 2.5 liters per minute per nasal cannula. He said he thought she was supposed to run at 2 liters per minute. He looked in the electronic medical records for Resident #234 and read her order for oxygen at 2 liters per nasal continuously for COPD. LVN G said that he checked the setting this morning when he started his shift. LVN G said that he thought the humidifier bottle moved the settings and LVN G put the setting at the correct rate. LVN G said that if resident receiving the incorrect order, the resident could be harm. LVN G said that the inservice were done frequently but could not remember the exact date.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/12/24 at 9:22 a.m., LVN E said that nurses were responsible to check every shift the oxygen settings at the beginning of the shift and at the end of the shift. LVN E said that if not administered the correct order the resident could be harm. LVN E could not remember when was the last inservice.<br><br>During an interview on 12/12/24 at 10:20 am, RN F said that the floor nurses were in charge to check the oxygen settings when starting the shift, during shift, and at the end of the shift. RN F said that if not giving the correct order to the resident, the resident could be hyper-oxygenated (too much oxygen). RN F said that the last inservice was yesterday.<br><br>During an interview on 12/12/24 at 2:00 pm with ADON said that the nurses were responsible to check the oxygen settings every shift, specially when was a continuous oxygen, ADON said that management made morning rounds each morning. the ADON said that an adverse reaction to the resident was that the oxygen level could drop if not administer the appropriate oxygen ordered by the physician. ADON said that the last inservice was last Friday.<br><br>During an interview on 12/12/24 at 3:06 p.m., the DON said the charge nurses were responsible for following the physician's orders and to check oxygen settings at the beginning of the shift and as needed during the shift and at the end of the shift. He said that if given less than the oxygen order the Resident's oxygen level could need more oxygen, and if given more than what was prescribed by the doctor, DON said that would not affect the resident if it was only increase by 0.5 liters per minute than the order. DON said that inservices were done weekly for the past few months and monthly.<br><br>Record review of facility policy titled, Oxygen Administration revision date as of April 2016, revealed it is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtain. |