STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676059	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Westchase	11910 Richmond Ave Houston, TX 77082

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview, and record review the facility failed to ensure Residents who are incontinent of bowel received appropriate treatment and services to prevent urinary tract infections for 1of 7 residents (Resident #3) reviewed for incontinent care in that: -Resident #3 did not receive incontinent care that followed infection control protocols. CNA A did not follow acceptable hand-sanitizing practices during incontinent care for Resident #3. These failures placed residents requiring incontinent care at risk of infections with the potential for complications and hospitalization . Findings include: Record review of Resident #3's face sheet dated 06/06/2024 revealed a [AGE] year-old admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (neurological disorder resulting in an alteration in mental status), dysphagia (difficulty swallowing food or liquid), cognitive communication deficit, acute kidney failure, morbid obesity due to excess calories, hemiplegia affecting the left side (paralysis), atherosclerotic heart disease (lesions on the arteries in the heart), hyperlipidemia (high levels of fat in the blood), glaucoma, and hypertension (high blood pressure). Record review of Resident #3's MDS (a resident assessment tool) dated 05/20/2024 revealed a BIMS score of 10, indicating moderately impaired cognition. Further record review revealed that Resident A required extensive assistance with activities and was always incontinent, meaning the helper does more than half the task for toileting. There was no UTI within the last 30 days of completing the MDS. Record review of Resident #3's care plan dated 05/20/2024 revealed that she has bowel incontinence and impaired mobility. Interventions include placing the call light within reach and providing peri-care after each incontinent episode by washing, rinsing, drying perineum, and changing clothing as needed after incontinence episodes. Interview on 06/06/24 at 11:41 a.m. with Resident #3, she said the staff do change her when she was dirty, and she was changed about two hours ago and she was wet, and she needed to be changed again. (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: 676059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Park Manor of Westchase		STREET ADDRESS, CITY, STATE, ZIP CODE 11910 Richmond Ave Houston, TX 77082	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 06/06/24 at 11:54 a.m., CNA A provided care for Resident #3, the CNA cleaned the resident's vagina area. CNA A wore gloves but did not wear a gown prior to providing care. Resident A had a series of bowel movements (BM); the CNA wiped Resident #3 three times, and on the fourth time the wipe did not have any BM on it. There was still a thin line of feces on the incontinent brief and a golf-sized BM attached to the resident rectum. CNA A said the resident could not push the BM out by herself most of the time. She then wiped the resident's rectum 8 more times and each time she wiped more BM came out of Resident #3's rectum. CNA A said wiping the resident helps her to have a BM. After every wipe, CNA A would change her gloves. CNA A did not sanitize her hand in between any glove changes. Interview on 06/06/24 at 1:51 p.m. with CNA A, with CNA B and the DON present, CNA A stated she has been at the facility for 1 year and 5 months. CNA A said the precautions by the door said she was supposed to put on PPE when she went into the room. She said she totally forgot and state surveyors conducting observations caught her off guard. CNA A said she did not sanitize her hands when she changed her gloves sometimes because she did not have any sanitizer in the room. She said using hand sanitizer was a precaution for bacteria. CNA A said she wiped BM from Resident #3's vagina, and there was BM still in her rectum. CNA A said she just finished showering Resident #3, that that while Resident #3 was in the shower she had a big BM, so CNA A cleaned her vagina while Resident #3 was sitting on the shower chair. CNA A said there was a little smear of BM on the incontinent brief because Resident #3 could not push out the BM in one sitting. She said if the resident had BM in her vagina the resident could have infection. CNA A said she had skills check off and in-services on incontinent care for residents. She said the nurse monitors the aides. She said she had in-services on infection control, and it included hand washing, donning (putting on PPE) and doffing (removing PPE) and PPE. Interview on 06/06/24 at 2:18 p.m., with the DON, said she expected the staff to don on gown and gloves before they go into a resident's room for incontinent care. She said it was for protection from different microorganisms. The DON said if the staff did not don PPE, they could spread germs. The DON said, You heard what the aide said, that she forgot. The DON said CNA A should have donned her PPE before going into her room and should have sanitized her hands between glove change to reduce the spread of germs. The DON said she thinks the BM in Resident #3's vagina was left over from the shower because you could not clean the vagina area well with the resident sitting on the shower chair. She said the resident could get infection, UTI, and bacteria can build up. The DON said when she became disabled, she expected the staff to clean her well and that she expected the same level of care for the resident. Record review of CNA A's in-service on incontinent care checks and pericarp dated 01/14/2024 revealed it was signed by CNA A. Record review of the facility's Infection Control Policies and Practices document revised August 2007 revealed that the objectives of their infection control policies are to prevent, detect, investigate and control infections in the facility and establish guidelines for implementing Standard precautions and that all personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Handwashing/Hand Hygiene policy statement revised August 2015 revealed that all personnel are to use an alcohol-based hand rub for such situations including before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, blood or bodily fluids, after handling contaminated equipment and after removing gloves. Record review of the facility's Perineal Care document revised October 2010 revealed that required equipment and supplies for performing this procedure included soap (or other authorized cleansing agent) and personal protective equipment. It also stated that after removing gloves and discarding them into a designated container, the personnel should wash and dry their hands thoroughly.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview, and record review, the facility failed to establish, and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 7 residents (Residents #3, #5 and #9) reviewed for infection control procedures in that: -CNA A did not use an alcohol-based sanitizer between changing gloves while providing incontinent care to Resident #3. -LVN A did not clean Resident #5's peri-wound (the area around a wound) before applying dressing during wound care. -LVN A did not remove his gown and gloves after leaving Resident B's room and came back in again and continued providing care to Resident #5. -LVN A did not remove his gown and gloves after leaving Resident #9's room and came back in again and continued providing care to Resident #9. These failures placed residents at risk of developing infections, communicable diseases and or hospitalization . Findings included: Record review of Resident #3's facesheet dated 06/06/2024 revealed a [AGE] year-old admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (neurological disorder resulting in an alteration in mental status), dysphagia (difficulty swallowing food or liquid), cognitive communication deficit, acute kidney failure, morbid obesity due to excess calories, hemiplegia affecting the left side (paralysis), atherosclerotic heart disease (lesions on the arteries in the heart), hyperlipidemia (high levels of fat in the blood), glaucoma, and hypertension (high blood pressure). Record review of Resident #3's quarterly MDS (a resident assessment tool) dated 05/20/2024 revealed a BIMS score of 10, indicating moderately impaired cognition. Further record review revealed that Resident A required extensive assistance with activities and was always incontinent, meaning the helper does more than half the task for toileting. There was no UTI within the last 30 days of completing the MDS. Record review of Resident #3's care plan dated 05/20/2024 revealed that she has bowel incontinence and impaired mobility. Interventions include placing the call light within reach and providing peri-care after each incontinent episode by washing, rinsing, drying perineum, and changing clothing as needed after incontinence episodes. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's facesheet dated 06/06/2024 revealed a [AGE] year-old originally admitted to the facility on [DATE]. Their medical diagnoses included: dementia, hyperlipidemia (high fat content in the blood), heart failure, peripheral vascular disease (accumulation of fat and cholesterol in the arteries), Anxiety Disorder, and hypertension (high blood pressure). Record review of Resident #5's quarterly MDS dated [DATE] revealed the BIMS was not completed because the resident is rarely or never understood. The Staff Assessment for Mental status revealed the resident is severely impaired and never or rarely makes their own decisions. Further review revealed that for toileting hyigene, Resident #5 is dependent, meaning the helper does all of the effort of this activity. Record review of Resident #5's care plan dated 05/15/2024 revealed that Resident #5 is incontinent of bowel and bladder with potential for skin breakdown, with interventions including checking skin daily, checking resident on rounds and change promptly. Resident #5 also has an ADL self care performance deficit due to dementia and impaired mobility, and requires extensive assist with 1-2 staff participating in toilet use care. Record review of Resident #9's facesheet dated 06/06/2024 revealed a [AGE] year-old originally admitted on [DATE]. Their medical diagnoses included: dysphagia (difficulty swallowing), Type 2 Diabetes Mellitus, acute kidney failure, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, Hypothyroidism (decreased production of hormones from the thyroid gland), and Hypertension (high blood pressure). Record review of Resident #9's quarterly MDS dated [DATE] revealed a BIMS score of 6, which indicates severe cognitive impairment. Further review revealed that for toileting hyigene, Resident #9 is dependent, meaning the helper does all of the effort of this activity. Record review of Resident #9's care plan revised on 02/15/2024 revealed that Resident #9 has bladder incontinence and is at risk for pressure ulcers. Interventions include: checking the resident during rounds and as required for incontinence, washing, rinsing and drying perineum and changing clothing as needed after incontinence episodes. Observation of Resident #5's wound measurement on 06/06/24 on 9:24 a.m. revealed the measurement by the WCD (Wound Care Doctor) of the resident's wound at 1.0x1.0cm. The WCD said the wound was 100% granulating tissues. He told the aide to reposition this resident every 2 to 3 hours. Observation and interview of Resident #5's wound care procedure 06/06/24 at 9:30 a.m., revealed the wound care nurse LVN A had cleaned the wound bed and padded it dry, but he did not clean the peri-wound and was about to apply dressing when the surveyor intervened. LVN A said he cleaned the wound itself but did not clean the peri-wound. LVN A wore the gown and the gloves he provided care for the resident and left the resident room and went to the treatment cart without doffing to get supplies and then came back and continued providing incontinent care. He said he should not have worn his gloves and gown outside and came back in because they were contaminated. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/06/24 at 9:34 a.m., Resident #9's wound was measured by the WCD at 1.03 x 0.9 x 0.2 cm. The WCD said the wound treatment could be discontinued if the area keeps improving. He told LVN A to keep turning the resident every 2 to 3 hours. LVN A performed care for the resident, and he went outside the resident's room again with his gown and gloves that he used to provide wound care for the resident. LVN A then re-entered Resident #9's room and continued to provide incontinent care with the same gloves and gown. Based on observation, interview, and record review, the facility failed to establish, and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 7 residents (Residents #3, #5 and #9) reviewed for infection control procedures in that: -CNA A did not use an alcohol-based sanitizer between changing gloves while providing incontinent care to Resident #3. -LVN A did not clean Resident #5's peri-wound (the area around a wound) before applying dressing during wound care. -LVN A did not remove his gown and gloves after leaving Resident B's room and came back in again and continued providing care to Resident #5. -LVN A did not remove his gown and gloves after leaving Resident #9's room and came back in again and continued providing care to Resident #9. These failures placed residents at risk of developing infections, communicable diseases and or hospitalization . Findings included: Record review of Resident #3's facesheet dated 06/06/2024 revealed a [AGE] year-old admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (neurological disorder resulting in an alteration in mental status), dysphagia (difficulty swallowing food or liquid), cognitive communication deficit, acute kidney failure, morbid obesity due to excess calories, hemiplegia affecting the left side (paralysis), atherosclerotic heart disease (lesions on the arteries in the heart), hyperlipidemia (high levels of fat in the blood), glaucoma, and hypertension (high blood pressure). Record review of Resident #3's quarterly MDS (a resident assessment tool) dated 05/20/2024 revealed a BIMS score of 10, indicating moderately impaired cognition. Further record review revealed that Resident A required extensive assistance with activities and was always incontinent, meaning the helper does more than half the task for toileting. There was no UTI within the last 30 days of completing the MDS. Record review of Resident #3's care plan dated 05/20/2024 revealed that she has bowel incontinence and impaired mobility. Interventions include placing the call light within reach and providing peri-care after each incontinent episode by washing, rinsing, drying perineum, and changing clothing as needed after incontinence episodes. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's facesheet dated 06/06/2024 revealed a [AGE] year-old originally admitted to the facility on [DATE]. Their medical diagnoses included: dementia, hyperlipidemia (high fat content in the blood), heart failure, peripheral vascular disease (accumulation of fat and cholesterol in the arteries), Anxiety Disorder, and hypertension (high blood pressure). Record review of Resident #5's quarterly MDS dated [DATE] revealed the BIMS was not completed because the resident is rarely or never understood. The Staff Assessment for Mental status revealed the resident is severely impaired and never or rarely makes their own decisions. Further review revealed that for toileting hyigene, Resident #5 is dependent, meaning the helper does all of the effort of this activity. Record review of Resident #5's care plan dated 05/15/2024 revealed that Resident #5 is incontinent of bowel and bladder with potential for skin breakdown, with interventions including checking skin daily, checking resident on rounds and change promptly. Resident #5 also has an ADL self care performance deficit due to dementia and impaired mobility, and requires extensive assist with 1-2 staff participating in toilet use care. Record review of Resident #9's facesheet dated 06/06/2024 revealed a [AGE] year-old originally admitted on [DATE]. Their medical diagnoses included: dysphagia (difficulty swallowing), Type 2 Diabetes Mellitus, acute kidney failure, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, Hypothyroidism (decreased production of hormones from the thyroid gland), and Hypertension (high blood pressure). Record review of Resident #9's quarterly MDS dated [DATE] revealed a BIMS score of 6, which indicates severe cognitive impairment. Further review revealed that for toileting hyigene, Resident #9 is dependent, meaning the helper does all of the effort of this activity. Record review of Resident #9's care plan revised on 02/15/2024 revealed that Resident #9 has bladder incontinence and is at risk for pressure ulcers. Interventions include: checking the resident during rounds and as required for incontinence, washing, rinsing and drying perineum and changing clothing as needed after incontinence episodes. Observation of Resident #5's wound measurement on 06/06/24 on 9:24 a.m. revealed the measurement by the WCD (Wound Care Doctor) of the resident's wound at 1.0x1.0cm. The WCD said the wound was 100% granulating tissues. He told the aide to reposition this resident every 2 to 3 hours. Observation and interview of Resident #5's wound care procedure 06/06/24 at 9:30 a.m., revealed the wound care nurse LVN A had cleaned the wound bed and padded it dry, but he did not clean the peri-wound and was about to apply dressing when the surveyor intervened. LVN A said he cleaned the wound itself but did not clean the peri-wound. LVN A wore the gown and the gloves he provided care for the resident and left the resident room and went to the treatment cart without doffing to get supplies and then came back and continued providing incontinent care. He said he should not have worn his gloves and gown outside and came back in because they were contaminated. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/06/24 at 9:34 a.m., Resident #9's wound was measured by the WCD at 1.03 x 0.9 x 0.2 cm. The WCD said the wound treatment could be discontinued if the area keeps improving. He told LVN A to keep turning the resident every 2 to 3 hours. LVN A performed care for the resident, and he went outside the resident's room again with his gown and gloves that he used to provide wound care for the resident. LVN A then re-entered Resident #9's room and continued to provide incontinent care with the same gloves and gown. Interview on 06/06/24 at 11:41 a.m. with Resident #3, she said the staff do change her when she was dirty, and she was changed about two hours ago and she was wet, and she needed to be changed again. Observation on 06/06/24 at 11:54 a.m., CNA A provided care for Resident #3, the CNA cleaned the resident's vagina area. CNA A wore gloves but did not wear a gown prior to providing care. Resident #3 had a series of bowel movements (BM); the CNA wiped Resident A three times, and on the fourth time the wipe did not have any BM on it. There was still a thin line of feces on the incontinent brief and a golf-sized BM attached to the resident's rectum. CNA A said the resident could not push the BM out by herself most of the time. She then wiped the resident's rectum 8 more times and each time she wiped more BM came out of Resident #3 ' s rectum. CNA A said wiping the resident helps her to have a BM. After every wipe, CNA A would change her gloves. CNA A did not sanitize her hand in between any glove changes. Interview on 06/06/24 at 1:51 p.m. with CNA A, with CNA B and the DON present, CNA A stated she has been at the facility for 1 year and 5 months. CNA A said the precautions by the door said she was supposed to put on PPE when she went into Resident #3's room. She said she totally forgot and state surveyors conducting observations caught her off guard. CNA A said she did not sanitize her hands when she changed her gloves sometimes because she did not have any sanitizer in the room. She said using hand sanitizer was a precaution for bacteria. CNA A said she had skills check off and in-services on incontinent care for residents. She said the nurse monitors the aides. She said she had in-services on infection control, and it included hand washing, donning (putting on PPE) and doffing (removing PPE) and PPE. Interview on 06/06/24 at 2:18 p.m., with the DON, the DON said CNA A should have should have sanitized her hands between glove change to reduce the spread of germs. She said the resident could get infection, UTI, and bacteria can build up. The DON said when she became disabled, she expected the staff to clean her well and that she expected the same level of care for the resident. Interview on 06/06/24 at 2:39 p.m., LVN A said, he was also the Wound Care Nurse. LVN A said he did not clean the peri-wound on Resident #5 and was about to apply the dressing when the surveyor intervened. He said it was important to clean the peri wound to keep the bacteria from entering the wound. He said the wound could get infected if the bacteria from the peri-wound entered the wound. He said he wore the PPE (gloves and gown) out the room and he should not have worn them outside because they were contaminated. He said the Infection Control Preventionist (ICP) and the DON monitored him during care to make sure he was providing the care appropriately. He said he had skills check off on wound care, and infection control which included hand washing and PPE. Interview on 06/06/2024 at 3:26pm with the Administrator, he said the staff would be retrained for the infection control issues which include donning and doffing of PPE. The administrator said the staff could make mistakes when they perform for somebody, but it was not an excuse. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/06/2024 at 3:27pm with the DON, she said LVN A should have donned and doffed the PPE the right way after he had provided wound care for the residents. The DON said peri-wound should be cleaned properly. She said if the peri-wound was not cleaned the bacteria from the peri wound could get into the wound, new microorganisms and necrosis and that sort of thing could happen and the wound could get worse. She said the DON and the ICP makes random rounds and monitor the wound care nurse. Interview on 06/06/24 at 3:54 pa.m. with the ICP, she said the staff coordinator used to do the in-services on incontinent care, but that person no longer work for the facility. She said her expectation for her nursing staff was that for residents on Enhanced Barrier Precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes) they don their PPE inside the resident's room by the doorway before they touch the resident; for residents isolation PPE has to be donned outside the room. She said the staff must doff inside the room before leaving the room. She said the staff should doff PPE in the room because it has been contaminated after staff provided care. Record review of the facility's Wound Care policy revised December 2011 revealed that this procedure requires PPE, including gowns, gloves, masks as needed. Personnel are to wear gloves when physically touching the wound or holding a moist surface over the wound and wash tissue around the wound with antiseptic or normal saline solution. Record review of the facility's Infection Control Policies and Practices document revised August 2007 revealed that the objectives of their infection control policies are to prevent, detect, investigate and control infections in the facility and establish guidelines for implementing Standard precautions and that all personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. Record review of the facility's Handwashing/Hand Hygiene policy statement revised August 2015 revealed that all personnel are to use an alcohol-based hand rub for such situations including before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, blood or bodily fluids, after handling contaminated equipment, after removing gloves, and before and after entering isolation precaution settings. Interview on 06/06/24 at 1:51 p.m. with CNA A, with CNA B and the DON present, CNA A stated she has been at the facility for 1 year and 5 months. CNA A said the precautions by the door said she was supposed to put on PPE when she went into Resident #3's room. She said she totally forgot and state surveyors conducting observations caught her off guard. CNA A said she did not sanitize her hands when she changed her gloves sometimes because she did not have any sanitizer in the room. She said using hand sanitizer was a precaution for bacteria. CNA A said she had skills check off and in-services on incontinent care for residents. She said the nurse monitors the aides. She said she had in-services on infection control, and it included hand washing, donning (putting on PPE) and doffing (removing PPE) and PPE. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/06/24 at 2:18 p.m., with the DON, the DON said CNA A should have should have sanitized her hands between glove change to reduce the spread of germs. She said the resident could get infection, UTI, and bacteria can build up. The DON said when she became disabled, she expected the staff to clean her well and that she expected the same level of care for the resident. Interview on 06/06/24 at 2:39 p.m., LVN A said, he was also the Wound Care Nurse. LVN A said he did not clean the peri-wound on Resident #5 and was about to apply the dressing when the surveyor intervened. He said it was important to clean the peri wound to keep the bacteria from entering the wound. He said the wound could get infected if the bacteria from the peri-wound entered the wound. He said he wore the PPE (gloves and gown) out the room and he should not have worn them outside because they were contaminated. He said the Infection Control Preventionist (ICP) and the DON monitored him during care to make sure he was providing the care appropriately. He said he had skills check off on wound care, and infection control which included hand washing and PPE. Interview on 06/06/2024 at 3:26pm with the Administrator, he said the staff would be retrained for the infection control issues which include donning and doffing of PPE. The administrator said the staff could make mistakes when they perform for somebody, but it was not an excuse. Interview on 06/06/2024 at 3:27pm with the DON, she said LVN A should have donned and doffed the PPE the right way after he had provided wound care for the residents. The DON said peri-wound should be cleaned properly. She said if the peri-wound was not cleaned the bacteria from the peri wound could get into the wound, new microorganisms and necrosis and that sort of thing could happen and the wound could get worse. She said the DON and the ICP makes random rounds and monitor the wound care nurse. Interview on 06/06/24 at 3:54 pa.m. with the ICP, she said the staff coordinator used to do the in-services on incontinent care, but that person no longer work for the facility. She said her expectation for her nursing staff was that for residents on Enhanced Barrier Precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes) they don their PPE inside the resident's room by the doorway before they touch the resident; for residents isolation PPE has to be donned outside the room. She said the staff must doff inside the room before leaving the room. She said the staff should doff PPE in the room because it has been contaminated after staff provided care. Record review of the facility's Wound Care policy revised December 2011 revealed that this procedure requires PPE, including gowns, gloves, masks as needed. Personnel are to wear gloves when physically touching the wound or holding a moist surface over the wound and wash tissue around the wound with antiseptic or normal saline solution. Record review of the facility's Infection Control Policies and Practices document revised August 2007 revealed that the objectives of their infection control policies are to prevent, detect, investigate and control infections in the facility and establish guidelines for implementing Standard precautions and that all personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Westchase	11910 Richmond Ave Houston, TX 77082

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Handwashing/Hand Hygiene policy statement revised August 2015 revealed that all personnel are to use an alcohol-based hand rub for such situations including before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, blood or bodily fluids, after handling contaminated equipment, after removing gloves, and before and after entering isolation precaution settings.