STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676073	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Quail Valley	2350 Fm 1092 Missouri City, TX 77459

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review, the facility failed to ensure personal privacy by securing signed consents for the use of security cameras for 1 of 2 (Resident #28) residents reviewed for privacy. The facility failed to ensure CNA A closed Resident #52's door or pulled the curtain when repositioning Resident #52 This failure could place residents at risk of embarrassment, and reduction of the self-esteem and self-worth by not being provided desired privacy during personal care or meetings with family or physicians. Findings included: Record review of Resident #52's face sheet print date of 05/01/2024, reflected a [AGE] year-old male initially admitted to the facility on [DATE]. His diagnoses included sequelae of unspecified cerebrovascular disease (restricted blood flow in veins), hemiplegia and hemiparesis (inability to move) following cerebral infarction affecting (loss of muscle control) left dominant side, hyperlipidemia (restricted blood flow), repeated falls, recurrent depressive disorders, anemia (low blood count), obstructive sleep apnea (relaxing of throat muscles blocking airway), claustrophobia (fear of being [NAME] stuffy or small spaces), type 2 diabetes mellitus (body's difficulty processing sugar) without complications, Oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), spinal stenosis (pressure on the spinal cord) cervical, gastro-esophageal reflux (contents of stomach move up into the muscles that move food from the mouth to the stomach) disease without esophagitis (inflammation of the muscles) encounter for attention to gastrostomy (medical procedure in opening of the stomach to introduce food), severe sepsis (infection in the body) with septic shock (bacterial infection causes low blood pressure, widening of the blood vessels), and dehydration (body's lack or loss of fluids) and aphasia-a language disorder that affects a person ability to communicate, Contracture-abnormal thickening of the skin. Record review of Resident #52's Quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 05 indicating severe impairment in thinking. Section H (Bladder and Bowel) reflected resident had an indwelling catheter (including suprapubic catheter and nephrostomy tube). Resident #52's functional status revealed he was dependent with on staff with bed mobility, transfer, dressing, personal hygiene and toilet use. Further review revealed Resident#52 had an indwelling Foley catheter. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #52's physician orders dated 02/27/23 revealed that Resident # 52 was to receive Skilled Care in a Long-term Care facility. Record review of Resident #52's Care Plan dated 02/12/2024 indicated Resident #52 was care planned for impaired communication evidence by no speech, rarely/never understood, and ADL self-care performance deficit. Observation on 05/01/24 at 2:31 PM, revealed Resident#52 lying in bed with door opened to the hallway and privacy curtain not pulled., Resident #52 was lying in bed, exposed; CNA A was seen at Resident #52's at bedside, with gloves on adjusting resident in bed. CNA A said she was repositioning resident in bed. Resident had a brief on, the flat bed cover was not on, theand Resident #52 and could be seen. Interview on 05/01/24 05/06/24 at 2:56 p.m., CNA A said she did not remember closing the door nor closing the curtain when repositioning. Interview on 05/01/24 at 2:38 p.m., the DON said whenever a staff member was providing care for a resident, they should either pull the privacy curtain or close the door to provide privacy. DON said Resident #52's family did not want the curtain pulled while providing care not the door. DON said her expectation while providing care was to provide privacy and dignity. The DON further stated an in-service would be done. Record review of the facility's policy on Resident Rights revised 2/2023 read in part: Personal privacy includes accommodations, medical treatment, written and telephone communications, and personal care.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on interview and record review, the facility failed to ensure a resident's assessment was completed within 7 and 14 days, and electronically transmit encoded, accurate, and complete MDS data to the CMS System for a subset of items upon a resident's transfer, reentry, discharge, and death for 2 of 2 discharged residents (CR #73 and CR #76) reviewed for encoding and transmitting resident assessments, in that: - The Facility failed to complete and transmit a discharge MDS for CR #73. - The Facility failed to complete and transmit a discharge MDS for CR #76. This failure could place discharged residents at risk of not having a proper discharge and not receiving services post discharge. Findings included: Record review of CR # 73's Face Sheet, dated 05/02/2024, reflected CR#73 was admitted on [DATE] and discharged on [DATE] with diagnoses including rheumatoid arthritis(chronic autoimmune disease that causes inflammation, or painful swelling in the joints), peripheral vascular disease(systemic disorder that involves the narrowing of peripheral blood vessels), gastro-esophageal reflux disease without esophagitis (gastric reflux occurs when stomach contents flow backward into the esophagus) , hyperlipidemia (an excess of lipids or fats in your blood), benign prostatic hyperplasia (not cancer condition in which an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine)with lower urinary tract symptoms, anemia (low blood volume), essential (primary) hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition), acute kidney failure(kidney suddenly become unable to filter waste product from the blood), acquired absence of other right toe(s), osteomyelitis. Record review of CR#73's MDS Assessment for discharge was not completed in a timely manner. CR #73 was discharged home on 12/16/2023, discharged MDS was completed on 01/29/2024. Record review of CR# 76's Face Sheet, dated 05/02/2024, reflected CR#76 was admitted on [DATE] and discharged on [DATE] with diagnoses including age-related osteoporosis (deterioration in bone mass and micro-architecture with increasing risk to fragility fracture) without current pathological fracture, spinal stenosis(narrow of the spine) lumbar region without neurogenic claudication (Clinical syndrome associated with symptom lumbar spinal stenosis) , type 2 diabetes mellitus without complications (adult increased glucose in the blood) , essential (primary) hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition) and hyperlipidemia (high fat in the blood). Record review of CR #76's discharge summary notes dated 11/11/23 revealed discharged home with home health care, ambulating with her walker. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #76's MDS Assessment for discharge was not completed in a timely manner. CR #76 was discharged home on 11/11/2023, discharged MDS was completed on 01/29/2024. Interview with the DON, RN on 5/2/24 at 10:01 AM, regarding timely completion of C R #73 and CR #76's discharge MDS. DON said Am not sure of the timeliness for discharged MDS, she would let the Medicare MDS nurse answer the questions. DON said accurate coding of dischargewould always benefit the resident and specify the treatment they can receive and help the facility to be paid for coding accurately with care the resident required or OIG(Office of the inspector general) would take their fund. Interview with LVN MDS PPS (Prospective Payment System), on 5/2/24 at 10:20 AM said she had been working with facility for [AGE] years, she coding the MDS accurately in timely manner is to show the residentthe resident care and help the facility losing money and when residents were discharged home or to the community. MDS completion she be done within 24 to 48 hours. she said she had personal issues going when Resident # 73 and Resident #76 were discharge from the facility. She was working from home at that taking care of a sick family members that was why it was done in a timely manner.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34463 Based on interview and record review, the facility failed to ensure assessments accurately reflected the status for 1 of 4 residents (CR#93) reviewed for MDS assessments. The facility failed to accurately code CR#93's discharge MDS assessment. This failure could place residents at risk of not receiving adequate care and services to meet their needs. Findings included: Record review of CR #93's face sheet revealed she was an [AGE] year old female that was admitted to the facility on [DATE] with a diagnosis of gout, chronic kidney disease, type 2 diabetes, hyperlipidemia, hypertension, and gastro-esophageal reflux. CR#93 was discharged from the facility on 02/29/24. Record review of CR#93's discharge MDS assessment dated [DATE] revealed she had an admitted [DATE] and was discharged on [DATE]. CR#93's discharge status was documented as Short-Term General Hospital. Record review of CR#93's progress notes revealed 2/29/2024 [11:03PM] Discharge Summary Note Text: Resident was discharged home in care of [family members] with all personal belongings and discharge paperwork @ [3:00] PM. Resident had large bowel movement before time of discharge. Cleansed and changed. Skin is warm and dry, intact without issues noted. Zinc applied to buttocks, sacrum, & coccyx after brief change. Resident was assisted to wheelchair. [Family member] gave resident dose of liquid Imodium in room @ [2:45] PM. Skilled nurse discussed discharge paperwork with [family members] - verbalized understanding. Resident sitting up, awake and alert, breathing even and unlabored. Responds to both physical and verbal stimuli well. Has no complaints of pain noted, no discomfort or acute distress seen at time of discharge. In an interview on 05/01/24 at 12:25 PM LVN D stated Resident #93 was discharged home with family, and she helped pack up Resident #93's belongings. Resident #93 was discharged with some medications. She helped the family put Resident #93 in the car. In an interview on 05/01/24 at 12:45 PM LVN C stated she made a mistake with Resident #93's MDS. The facility has so many residents being discharged she made a mistake. The resident was discharged to a personal care home not an acute hospital. She may have mixed up the resident with someone else. In an interview on 5/1/24 at 1:04 PM the DON stated the LVN C reviewed the MDS and the DON also reviewed the MDS for accuracy but the DON does not go through the MDS line by line. Record review of the policy for MDS provided by the ADM did not address the accuracy of MDS completion.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #52) of 8 residents reviewed for care plans. The facility failed to ensure Resident #52's care plan reflected he had a foley catheter. This failure could place residents at risk of not receiving appropriate care to meet their current needs. The findings included: Record review of Resident #52's face sheet print date of 05/01/2024, reflected a [AGE] year-old male initially admitted to the facility on [DATE]. His diagnoses included sequelae of unspecified cerebrovascular disease (restricted blood flow in veins), hemiplegia and hemiparesis (inability to move) following cerebral infarction affecting (loss of muscle control) left dominant side, hyperlipidemia (restricted blood flow), type 2 diabetes mellitus (body's difficulty processing sugar) without complications, severe sepsis (infection in the body) with septic shock (bacterial infection causes low blood pressure, widening of the blood), and dehydration (body's lack or loss of fluids). Record review of Resident #52's Quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 05 indicating severe impairment in thinking. Section H (Bladder and Bowel) reflected resident had an indwelling catheter (including suprapubic catheter and nephrostomy tube). Record review of Resident #52's Comprehensive Care Plan last revision date of 01/26/2024, did not address the resident's use of an indwelling catheter to include the focus, goals, or interventions. During an interview on 04/29/2024 at 08:52 a.m., LVN A stated that she had been in her role at the facility the last 5-years and was responsible for MDS coding, care plans, restorative care plans, and long-term care plan referrals. She stated that Resident #52 admitted from the hospital with a foley catheter. She stated she completed the resident's annual comprehensive care plan and during the process, she physically assessed the resident. She stated that she did not care plan the resident's use of a catheter on his care plan, she had just missed it. She stated she had coded the use of the catheter on the resident's MDS. She stated that there were no direct adverse effects from her missing the coding on his care plan because the staff could reference to the resident's electronic profile for his care needs and diagnosis. She stated that staff would also see the catheter upon a physical check of the resident. She stated staff knowing the resident had a catheter beforehand would alert them to check for correct placement on the resident, ensure no kinks were in the line, and that it was properly hanging from the resident's bed. She stated the purpose of the care plan was to give the staff the heads up on a resident's condition and care needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Care Plans, Comprehensive Person-Centered Policy last revision date of December 2016. Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. 44669 48923 Based on observation, interview and record review, the facility failed to provide services that develop and implement a comprehensive person-centered care plan to meet a resident's medical needs for 1 of 8 residents (Resident #8) in that: 1. Resident #8 was not wearing geri-sleeves on 4/30/2024 at 9:43am and 2:05pm as ordered by the physician. This deficient practice could affect 2 residents who had orders for geri-sleeves (arm sleeves that help prevent skin shearing and tearing) in their care plan and places them at risk of not receiving the care and services to meet their needs. Findings included: Record review of Resident #8's Facesheet revealed an [AGE] year-old female resident who was admitted on [DATE]. Her medical diagnoses included rhematic rheumatic mitral stenosis (narrowing of one of a heart's valve), atherosceleroticatherosclerotic heart disease (a disease where fat deposits, also called plaque, build up in the arteries and limit blood flow to the heart), essential hypertension (high blood pressure), Generalized Anxiety Disorder (persistent, severe anxiety that interferes with daily activities) and Metabolic Encephalopathy (disorder of the brain due to illness such as diabetes, renal and/or heart failure). Record review of Resident #8's MDS quarterly assessment dated [DATE] revealed a BIMS (an assessment to determine a resident's level of cognitive function, scored out of 15 with 15 being cognitively intact) score of 4, which indicates severe cognitive impairment. Record review of the facility's incident report revealed Resident #8 had skin tears treated on 5/13/23, 7/5/23, 12/18/23, 1/30/24, 3/23/24 and 4/15/24. Further review of the incident on 3/23/24 revealed a nurse's note detailing that resident has been wearing geri-sleeves to prevent bruising due to her paper thin skin. Record review of Resident #8's Physician's Orders dated 12/18/2023 revealed an active order for geri sleeves to bilateral arms, remove to assess arms, and replace for protection for every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's care plan revealed they did not address geri-sleeves in the resident's care plan. Record review of Resident #8's TAR revealed she had geri-sleeves placed on her for the day and evening shift on 4/30/2024. Record review of Resident #8's progress notes revealed no documentation of Resident #8 refusing geri-sleeves for 4/30/2024. Observation of Resident #8 on 4/30/2024 at 9:43am and 2:05pm revealed Resident #8 was not wearing geri-sleeves and she had 1 cm oval bruises on her outer left hand and inner right knuckle. Observation of Resident #8 on 5/1/24 at 10:00am revealed she was sleeping with manila yellow geri-sleeves and thumb cut-outs on. Interview with Resident #8 on 4/30/2024 at 9:43am revealed she was unable to answer if she was in pain, how she got her bruises, nor how long she has been at the facility. Interview with RN A on 5/2/2024 at 9:30am, who initialed that Resident #8 had geri-sleeves placed on arms on 04/30/2024. When asked about why Resident #8 did not wear geri-sleeves on 04/30/2024, they stated that Resident #8 takes them off herself on days they areshe is more alert and nursing tries to put the sleeves back on, but after multiple attempts will let her keep it off. She does not listen when asked to keep the geri-sleeves on. She takes them off because she's itching, and that's why she gets skin tears. When Resident #8 is sleepy she will keep the sleeves on all day. Resident #8 can be resistive to care such as taking medication or being changed.

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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** 16352 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #52) reviewed for incontinent care. 1.The facility failed to ensure CNA A cleaned Resident #52's indwelling Foley catheter properly and followed proper hand hygiene during incontinent care. These failures could place residents at risk for pain, infection, injury, and hospitalization . Finding included: Record review of Resident #52's face sheet print date of 05/01/2024, reflected a [AGE] year-old male initially admitted to the facility on [DATE]. His diagnosesis included sequelae of unspecified cerebrovascular disease (restricted blood flow in veins), hemiplegia and hemiparesis (inability to move) following cerebral infarction affecting (loss of muscle control) left dominant side, hyperlipidemia (restricted blood flow), type 2 diabetes mellitus (body's difficulty processing sugar) without complications, severe sepsis (infection in the body) with septic shock (bacterial infection causes low blood pressure, widening of the blood), and dehydration (body's lack or loss of fluids) and obstructive and reflux uropathy, (when urine cannot drain through the urinary tract), benign prostatic hyperplasia (overgrowth of prostate tissue pushes against the urethra and bladder blocking the flow of urine) and urinary tract infection (bacteria invade and grow in the urinary tract (kidneys, ureters, bladder, and urethra). Record review of Resident #52's Quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 05 indicating severe impairment in thinking. Section H (Bladder and Bowel) reflected resident had an indwelling catheter (including suprapubic catheter and nephrostomy tube). Resident #52's functional status revealed he was independent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident#52 had an indwelling Foley catheter. Record review of Resident #52's physician order dated from February 2023 through April 2024 read in part . change Foley catheter with 18 inch catheter and 10cc bulb on the 1st of each month dated 12/22/23 . keep catheter from kinks and drainage bag lower than bladder at all times dated 2/27/23 . Bactrim DS tablet 800-160 mg 1 tablet x 5 days DX: urinary tract infection order date 01/29/ 24 - 02/03/24 . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/01/24 at 2:31 PM, incontinent care was provided for Resident #52 by CNA A and CNA B was assisting. CNA A placed the cleaned linen on resident bedside table, got gray basin with warm water, poured in peri care wash, using the face towel in a soapy water, she wash hands, don gloves , open the soiled brief, catheter was secured, CNA A using the wet face towel cleaning the catheter from outward toward the urethral site(inward), she then cleaned the groin, did not pulled back the foreskin to cleaned, she then picked up the cleaned brief and placed it on the foot of the bed, CNA A repositioned the resident to side, he had small amount of BM, she cleaned in-between the buttocks, she then removed dirty gloves, got the trash bag from her uniform pocket then placed on the floor, she then don cleaned gloves without washing hands or using hand sanitizer. Interview with CNA B on 5/1/24 at 2:50 PM who was assisting CNA A . Surveyor asked about the technique for incontinent care performed by C.NA A. CNA B said CNA A did not changed gloves she placed dirty linen on the bedside table, placed trash bag on the floor and did not cleaned the catheter well, she was cleaning the catheter from upward to insertion site. Interview with CNA A on 5/1/24 at 2:54 PM, regarding incontinent care she said, she had not had in-services, since she started working August 2023, she was taught differently in the state she came from. She said nobody or staff had monitored her on incontinent care. During an interview on 5/1/24 at 3:30 PM the DON said indwelling catheters should be cleaned from the insertion site outward in a circular motion. The DON said her expectation for indwelling catheters was for the cleaning to be done well so the resident would not have any infection. DON said the ADON, and the lead C. NA does incontinent care and indwelling Foley training upon hire and randomly. Interview with the ADON on 5/1/24 at 3:45PM regarding incontinent training and indwelling catheter training for C.NA A, ADON said the lead aide trained C.NA A and he was off duty. Record review of the facility policy for Catheter Care Urinary date 3/31/2016 revealed: For the male: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. 16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review, the facility failed to ensure that drugs and biologicals used in the facility were accurately acquired, received, dispensed, and administered in accordance with currently accepted professional standards for 1 of 1 resident (#447), 2 of 4 medication carts (400 hall nurse cart and 100 hall medication aide cart) and 1 of 1 medication room reviewed for medication storage. - At bedside of Resident #447 were Equate (brand name) lubricant eye drops 0.5 oz. - The 400-hall nurse's medication cart contained discontinued ipratropium bromide inhalation solution, sore throat spray, and genteel tears and there was no expiration date on medication: zinc oxide ointment skin protectant. - The refrigerator in the medication room contained insulin, which was not in its delivery packet for Resident #87, insulin for Resident #201, who was discharged , latanoprost for Resident #24, who was discharged , and latanoprost eye drop which was not in delivery packet, and had no name. - The 100-hall medication aide's cart contained discontinued medication for Resident #24 who was discharged : hydralazine 25mg. These failures placed all residents at risk of harm or decline in health due to lack of potency of medications and expired medical supplies and risk of medication misuse and drug diversion Findings included: 1 Record review of Resident #447's face sheet print date of 04/30/2024, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included legal blindness, displaced fracture of lateral condyle of right humerus, subsequent encounter for fracture with routine healing, and unspecified fall subsequent encounter. Record review of Resident #447's admission Minimum Data Set (MDS) assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section B (Hearing, Speech and Vision) reflected ability to see in adequate light (with glasses or other visual appliance resident: Highly impaired - object identification in question, but eyes appear to follow objects. Record review of Resident #447's Functional Abilities and Goals - Admission MDS Reason for Evaluation dated 04/25/2025, reflected resident: Needed Some Help - Resident needed partial assistance from another person to complete activities. Functional Limitations Range of Motion: Impairment on one side. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676073	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Quail Valley	2350 Fm 1092 Missouri City, TX 77459

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #447's's active physician's orders dated 04/30/3034 reflected, Propylene Glyco Ophthalmic Solution 0.6% (Propylene Glycol (Ophth)). Instill 1 drop in both eyes two times a day for dry eyes wait 3-5 minutes between each drop start date 4/30/2024. There were no orders for self-administration of medications. Record review of Resident #447's Medication and Treatment Administration Records (MAR) for April 2024, reflected she had received the Propylene Glyco Ophthalmic Solution twice a day beginning 04/30/2024 6:00 p.m. Record review of Resident #447's comprehensive care plan undated. Diagnosis: legal blindness. The care plan did not address self-administration of medications. Record review of Resident #447's Progress Note dated 4/30/2024 5:01 p.m. health status note text: new order from Nurse Practitioner to start Propylene Glycol Ophthalmic Solution 0.6 % (Propylene Glycol (Ophth)) per patient's request. Family made aware and agreed. During an observation on 04/29/2024 at 08:52 a.m., Resident #447 lying in bed with right arm in a sling. On the left side of resident's bed on bedside table: Equate (brand name) lubricant eye drops 0.5 oz. During an observation on 04/30/2024 at 12:38 p.m., lubricated eye drops on Resident #447's sitting on bedside table. During an interview on 04/29/24 at 08:52 a.m., Resident #447 stated that, she was supposed to be given and had not received eye drops 2x a day. She stated that her eyes felt like they had rock in them. She stated that she was legally blind. She stated that she had eye drops sitting on bedside table and asked could they be administered. During an interview on 04/30/2024 at 12:38 p.m., Resident #447 stated that she had not received her eye drops and pointed to the bedside table asking that they be administered. During an interview on 05/01/2024 at 08:19 a.m., Resident #447 stated that she had not received her eye drops 04/30/2024 or 05/01/2024. She stated that the staff took the eye drops that were sitting on the bedside table. During an interview on 05/02/2024 at 11:42 a.m., the Administrator stated that he was not aware that medication had been found at Resident #447's bedside. He stated the importance of following the self-administration policy was to ensure that the dosages were documented, orders followed, and residents were not administering too much medication. He stated that he would provide the policy on medication administration. He stated it was his expectation that staff immediately remove any medications at beside. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/2024 at 2:20 p.m., Director of Nursing (DON) stated that Resident #447 was a new resident. She stated that the resident was not care planned for self-medication administration. She stated that the eye drops found at resident's bedside were taking and placed in the medication cart. She stated that the resident's family was contacted and notified. She stated that families often bring medications. She stated that the facility would never want a resident with dementia to wander into a residents' room and self-administer. She stated it was always relayed to families at admission that medications even over the counter, must be checked in and kept in the medication cart for the safety of all residents. She stated it was her expectations that all staff take found meds away from bedside and let the resident know that it would be placed in the med cart and notify the family that it could be pick up. 2. During observation and interview on 04/30/24 at 9:30 a.m., for 400 hall nursing medication cart with LVN B revealed Resident # 200's ipratropium bromide inhalation solution, and Resident #201's sore throat spray and genteel tears. It also showed a jar of zinc oxide ointment skin protectant had no expiration date. LVN B said the physician discontinued these residents' medications, and she could not remember when the physician discontinued the medicines. LVN B said medication should be removed from the cart once discontinued to prevent the nurses from administering the wrong medication. LVN B did not respond to what could happen to a resident if the nurse administered the wrong medication. LVN B said the zinc oxide should have an expiration date, but she could not find the expiration date on the container. LVN B said she had skills checkoffs for medication storage, and the unit manager randomly did cart audits for discontinued and expired medication. During an interview on 04/30/24 at 9:34 a.m., Unit Manager M said medications were taken out of the cart as soon as it was discontinued to prevent the nurses from administering the discontinued medication by mistake, which would be a medication error. Unit Manager M said the nurse was responsible for pulling discontinued and expired medications from the cart. She stated all medications and ointments used in the facility should have an expiration date, preventing the nurses from administering expired medication to residents, which could cause undesirable effects for the residents. 3. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/30/24 at 10:01 a.m., the refrigerator in the medication room with Unit Manager Y revealed that Resident #87's Insulin Lispro injection U- 100 was not in any delivery container and did not include administration instruction or expiration date. Unit Manager Y said she did not know why the medication was not in the packet in which it was delivered from the pharmacy, or the pharmacy may have delivered it without a package since it was a single pen. Unit Manager Y said the nursing staff should store medication in its original packet. Observation also revealed that the cart contained Resident #201's Insulin Lispro injection U- 100 pen, which was not opened Unit Manager Y said she could not remember when the nursing staff sent Resident #201 to the hospital. Unit Manager Y stated that since the insulin was not opened, she thought keeping it in the refrigerator was safe. Unit manager Y said she did not know the facility policy for medication storage for residents who went to the hospital. Unit Manager Y said she would check and get back to the surveyor. Resident #24 had latanoprost solution 0.005% in the refrigerator. The unit manager said she sent Resident #24 to the hospital last night (04/29/24), which was why Resident #24's eye drop medication was still in the refrigerator. Further review of the fridge revealed one latanoprost ophthalmic solution was not in any pack and had no name. Unit Manager Y said she did not know which resident the eye drop belonged to, and it should have been in the original packet, which was delivered from the pharmacy. Unit Manager Y said the nursing staff should discard discontinued medications into the discontinued box if the resident was discharged from the facility or the medication did not have any resident information. Unit Manager Y said unit managers made random rounds in the medication room and made sure all discontinued and discharged residents were placed in the barrel. 4. During an observation and interview on 04/30/24 at 2:05 p.m. of 100 hall medication aide cart with MA I revealed Resident #24 had four blister packets of Hydralazine 25 mg. MA I said the nursing staff sent Resident #24 to the hospital, but Hydralazine 25 mg was discontinued before Resident #24 was sent to the hospital. MA I said when the physician discontinued Resident #24's medication, the medication aide should have removed it from the cart as soon as it was discontinued to prevent administering the wrong medication. That would be a medication error, and the resident may not get the desired effect. MA I said the medication aide should take the medications from the cart and put them in the locked barrel in the medication room. MA I said the unit manager made rounds and checked the carts randomly for discharged or expired medications. MA I said she was trained in medication storage. During an observation and interview on 04/30/24 at 2:30 p.m., with the DON and Unit Manager Y, Unit Manager Y said Resident #24 was still on 25 mg of hydralazine 25 mg and the medication was still in the cart because Resident #24 was sent to the hospital last night (04/29/24). Unit Manager Y said the facility left the medicines on the cart for about a week for the resident who was sent to the hospital, but she was unsure if it was the facility protocol. Then, Unit Manager Y looked at the EMAR and said the 25 mg of hydralazine was discontinued on 04/16/24. Unit Manager Y said the medication aides should have removed the medication from the cart to prevent administrating the wrong dosage, which would not provide the desired effect. The DON said the medication aide should have removed the medication from the cart as soon as the physician changed the dosage to prevent administering the wrong dosage. The DON said the nursing managers are responsible for medication cart audits. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/24 at 3:28 p.m., the DON said the pharmacy may have sent the insulin pen without a packet, but the eye drop without name or instruction did not come from the pharmacy without a packet. She said she did not know what happened to the eye drop packet, and it should have been disposed or sent back to the pharmacy. The DON said if a resident was sent to the hospital, the medication could be kept in the medication cart and medication room for up to 5 days before it would be removed and dropped into the discontinued barrel. The DON said she would check and see if it was the facility policy and get back to the surveyor. The DON said the nurse managers made random cart audits and medication rooms audits to remove discontinued and discharged resident medication to avoid administration of any of the medicines in error, which could have different adverse effects on the resident, but she did not respond on the types of adverse effects. Record review of the facility's Revised December 2012 dated policy: Administering Medications. Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 3. Medications must be administered in accordance with the orders, including any required time frame. 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Record review of the facility's Revised December 2016 dated policy: Self-Administration of Medications. Policy Statement: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation Record review of the facility's Revised December 2016 dated policy: Resident Rights. Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: hh. self-administer medication, if the interdisciplinary care planning team determines it is safe; Record review of facility's Care Plans, Comprehensive Person-Centered Policy last revision date of December 2016. Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy on medication storage date 2001 MED - PASS, Inc. (Revised April 2007) read in part . The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . #1 .drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers . 2 .the nursing staff shall be responsible for maintaining medication storage . 3 . drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing . 4 . the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals . 44669 Based on observation, interview, and record review the facility failed to ensure the interdisciplinary team determined provisions of self-administration of medication was safe and consistent with professional standards of practice for 1 of 1 resident reviewed for self-administration of medications. (Residents #447). The facility failed to access and determine if residents could safely self-administer medications for Residents #447. This failure could place residents at risk of not receiving the proper medication, the proper dose, or the therapeutic benefits of the medications. Findings included: Record review of Resident #447's face sheet print date of 04/30/2024, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included legal blindness, displaced fracture of lateral condyle of right humerus, subsequent encounter for fracture with routine healing, and unspecified fall subsequent encounter. Record review of Resident #447's admission Minimum Data Set (MDS) assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section B (Hearing, Speech and Vision) reflected ability to see in adequate light (with glasses or other visual appliance resident: Highly impaired - object identification in question, but eyes appear to follow objects. Record review of Resident #447's Functional Abilities and Goals - Admission MDS Reason for Evaluation dated 04/25/2025, reflected resident: Needed Some Help - Resident needed partial assistance from another person to complete activities. Functional Limitations Range of Motion: Impairment on one side. Record review of Resident #447's's active physician's orders dated 04/30/2024 reflected, Propylene Glyco Ophthalmic Solution 0.6% (Propylene Glycol (Ophth)). Instill 1 drop in both eyes two times a day for dry eyes wait 3-5 minutes between each drop start date 4/30/2024. There were no orders for self-administration of medications. Record review of Resident #447's Medication and Treatment Administration Records (MAR) for April 2024, reflected she had received the Propylene Glyco Ophthalmic Solution twice a day beginning 04/30/2024 6:00 p.m. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #447's comprehensive care plan undated. Diagnosis: legal blindness. The care plan did not address self-administration of medications. Record review of Resident #447's Progress Note dated 4/30/2024 5:01 p.m. health status note text: new order from Nurse Practitioner to start Propylene Glycol Ophthalmic Solution 0.6 % (Propylene Glycol (Ophth)) per patient's request. Family made aware and agreed. During an observation on 04/29/2024 at 08:52 a.m., Resident #447 lying in bed with right arm in a sling. On the left side of resident's bed on bedside table: Equate (brand name) lubricant eye drops 0.5 oz. During an observation on 04/30/2024 at 12:38 p.m., lubricated eye drops on Resident #447's sitting on bedside table. During an interview on 04/29/24 at 08:52 a.m., Resident #447 stated that, she was supposed to be given and had not received eye drops 2x a day. She stated that her eyes felt like they had rock in them. She stated that she was legally blind. She stated that she had eye drops sitting on bedside table and asked could they be administered. During an interview on 04/30/2024 at 12:38 p.m., Resident #447 stated that she had not received her eye drops and pointed to the bedside table asking that they be administered. During an interview on 05/01/2024 at 08:19 a.m., Resident #447 stated that she had not received her eye drops 04/30/2024 or 05/01/2024. She stated that the staff took the eye drops that were sitting on the bedside table. During an interview on 05/02/2024 at 11:42 a.m., the Administrator stated that he was not aware that medication had been found at Resident #447's bedside. He stated the importance of following the self-administration policy was to ensure that the dosages were documented, orders followed, and residents were not administering too much medication. He stated that he would provide the policy on medication administration. He stated it was his expectation that staff immediately remove any medications at beside. During an interview on 05/02/2024 at 2:20 p.m., Director of Nursing (DON) stated that Resident #447 was a new resident. She stated that the resident was not care planned for self-medication administration. She stated that the eye drops found at resident's bedside were taking and placed in the medication cart. She stated that the resident's family was contacted and notified. She stated that families often bring medications. She stated that the facility would never want a resident with dementia to wander into a residents' room and self-administer. She stated it was always relayed to families at admission that medications even over the counter, must be checked in and kept in the medication cart for the safety of all residents. She stated it was her expectations that all staff take found meds away from bedside and let the resident know that it would be placed in the med cart and notify the family that it could be pick up. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Revised December 2012 dated policy: Administering Medications. Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 3. Medications must be administered in accordance with the orders, including any required time frame. 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Record review of the facility's Revised December 2016 dated policy: Self-Administration of Medications. Policy Statement: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation Record review of the facility's Revised December 2016 dated policy: Resident Rights. Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: hh. self-administer medication, if the interdisciplinary care planning team determines it is safe; Record review of facility's Care Plans, Comprehensive Person-Centered Policy last revision date of December 2016. Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked storage area and to limit access to authorized personnel for 1 of 1 resident (#447) room reviewed for medication storage. -The facility failed to ensure all drugs and biologicals were stored in locked storage area and limited access to authorized personnel. These deficient practices could place residents at risk of medication misuse and drug diversion. Findings included: Record review of Resident #447's face sheet print date of 04/30/2024, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included legal blindness, displaced fracture of lateral condyle of right humerus, subsequent encounter for fracture with routine healing, and unspecified fall subsequent encounter. Record review of Resident #447's admission Minimum Data Set (MDS) assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section B (Hearing, Speech and Vision) reflected ability to see in adequate light (with glasses or other visual appliance resident: Highly impaired - object identification in question, but eyes appear to follow objects. Record review of Resident #447's Functional Abilities and Goals - Admission MDS Reason for Evaluation dated 04/25/2025, reflected resident: Needed Some Help - Resident needed partial assistance from another person to complete activities. Functional Limitations Range of Motion: Impairment on one side. Record review of Resident #447's's active physician's orders dated 04/30/3034 reflected, Propylene Glyco Ophthalmic Solution 0.6% (Propylene Glycol (Ophth)). Instill 1 drop in both eyes two times a day for dry eyes wait 3-5 minutes between each drop start date 4/30/2024. There were no orders for self-administration of medications. Record review of Resident #447's Medication and Treatment Administration Records (MAR) for April 2024, reflected she had received the Propylene Glyco Ophthalmic Solution twice a day beginning 04/30/2024 6:00 p.m. Record review of Resident #447's comprehensive care plan undated. Diagnosis: legal blindness. The care plan did not address self-administration of medications. Record review of Resident #447's Progress Note dated 4/30/2024 5:01 p.m. health status note text: new order from Nurse Practitioner to start Propylene Glycol Ophthalmic Solution 0.6 % (Propylene Glycol (Ophth)) per patient's request. Family made aware and agreed. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/29/2024 at 08:52 a.m., Resident #447 lying in bed with right arm in a sling. On the left side of resident's bed on bedside table: Equate (brand name) lubricant eye drops 0.5 oz. During an observation on 04/30/2024 at 12:38 p.m., lubricated eye drops on Resident #447's sitting on bedside table. During an interview on 04/29/24 at 08:52 a.m., Resident #447 stated that, she was supposed to be given and had not received eye drops 2x a day. She stated that her eyes felt like they had rock in them. She stated that she was legally blind. She stated that she had eye drops sitting on bedside table and asked could they be administered. During an interview on 04/30/2024 at 12:38 p.m., Resident #447 stated that she had not received her eye drops and pointed to the bedside table asking that they be administered. During an interview on 05/01/2024 at 08:19 a.m., Resident #447 stated that she had not received her eye drops 04/30/2024 or 05/01/2024. She stated that the staff took the eye drops that were sitting on the bedside table. During an interview on 05/02/2024 at 11:42 a.m., the Administrator stated that he was not aware that medication had been found at Resident #447's bedside. He stated the importance of following the self-administration policy was to ensure that the dosages were documented, orders followed, and residents were not administering too much medication. He stated that he would provide the policy on medication administration. He stated it was his expectation that staff immediately remove any medications at beside. During an interview on 05/02/2024 at 2:20 p.m., Director of Nursing (DON) stated that Resident #447 was a new resident. She stated that the resident was not care planned for self-medication administration. She stated that the eye drops found at resident's bedside were taking and placed in the medication cart. She stated that the resident's family was contacted and notified. She stated that families often bring medications. She stated that the facility would never want a resident with dementia to wander into a residents' room and self-administer. She stated it was always relayed to families at admission that medications even over the counter, must be checked in and kept in the medication cart for the safety of all residents. She stated it was her expectations that all staff take found meds away from bedside and let the resident know that it would be placed in the med cart and notify the family that it could be pick up. Record review of the facility's Revised December 2012 dated policy: Administering Medications. Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 3. Medications must be administered in accordance with the orders, including any required time frame. 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Record review of the facility's Revised December 2016 dated policy: Self-Administration of Medications. Policy Statement: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676073	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Quail Valley	2350 Fm 1092 Missouri City, TX 77459

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation Record review of the facility's Revised December 2016 dated policy: Resident Rights. Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: hh. self-administer medication, if the interdisciplinary care planning team determines it is safe; Record review of facility's Care Plans, Comprehensive Person-Centered Policy last revision date of December 2016. Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;

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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** 16352 Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1 of 2 residents (Resident #52) and 1 of 2 staff (CNA A) reviewed for incontinent care as indicated by: The facility failed to ensure CNA A washed or sanitized her hands after doffing (taking off) dirty gloves and went to clean linen cart parked on the hallway for linen. This deficient practice placed residents at risk for cross contamination and the spread of infection. Findings included: Record review of Resident #52's face sheet print date of 05/01/2024, reflected a [AGE] year-old male initially admitted to the facility on [DATE]. His diagnosis included sequelae of unspecified cerebrovascular disease (restricted blood flow in veins), hemiplegia and hemiparesis (inability to move) following cerebral infarction affecting (loss of muscle control) left dominant side, hyperlipidemia (restricted blood flow), type 2 diabetes mellitus (body's difficulty processing sugar) without complications, severe sepsis (infection in the body) with septic shock (bacterial infection causes low blood pressure, widening of the blood), and dehydration (body's lack or loss of fluids). Record Review of the most recent quarterly MDS assessment dated [DATE] reflected Resident #52 had a BIMS score of 05 indicating Resident #52 was severely cognitively impaired and not able to answer the interview . MDS reflected resident was always continent of bladder and frequently incontinent of bowel. Record review of Residents # 52's care plan dated 08/16/23 reflected resident had bowel incontinence. Goal: The resident will not have any complications r/t (related to) bowel incontinence Interventions: Apply barrier cream after every incontinent episode. Check resident every two hours and assist with toileting as needed. Provide peri care after each incontinent episode. Report any skin change to the nurse immediately. Observation on 05/01/24 at 2:31 PM, revealed Resident #52 lying in bed. CNA A was seen at bedside, with gloved hand on adjusting resident in bed. CNA A took off dirty gloves without washing her hands or use hand sanitizer and went to the clean linen cart parked on the hallway and got clean towels and bed linen. CNA A placed the clean linen on resident bedside table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/24 at 2:55 PM with CNA A, CNA A stated she had been trained on infection control not in facility but had not been told specifically to wash or sanitize hands when going from a dirty to clean surface. C.NA A stated if she did not wash or sanitize her hands when going from a dirty to clean surface, it could cause cross contamination and a risk of transferring infection. In an interview on 05/02/24 at 3:45 PM with the DON, she stated it was the facility's policy for staff to wash or sanitize hands when going from a dirty to clean surface. She stated staff had been in-serviced on infection control and hand hygiene. She stated if hand hygiene or sanitizing was not performed when going from a dirty to clean surface, it could cause an infection. Record review of the undated facility policy titled Hand Hygiene, provided by the ADM, revealed the following: You may use alcohol based hand cleaner or soap/water for the following: Before and after assisting resident with personal care (e.g., oral care, bathing); Upon and after coming in contact with a resident's intact skin; After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans, catheters and urinals; After removing gloves or aprons.