STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676153	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of League City	2620 W Walker League City, TX 77573

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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 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** 26867 Based on record review and interviews, the facility failed to electronically transmit within 14 days after the facility completed a resident's assessment, encoded MDS data including a subset of items upon a resident's transfer, reentry, discharge, and death for 3 of 3 residents (CR #16, 44, and #114) reviewed for electronic transmission of MDS data to the CMS system. The facility failed to complete and transmit discharge MDS data to the CMS system for (CR #16, 44, and #114 residents within 14 days of Residents discharge from the facility. These failures could place residents at risk for not having their assessments transmitted timely and or having their long-term care nursing facility Medicaid payments and or services interrupted. Findings Include: CR #16 Record review of CR #16's Face Sheet dated 08/21/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of restlessness and agitation, respiratory failure, chronic kidney disease (long standing disease of the kidneys leading to kidney failure), pain, type 2 diabetes, and generalized anxiety. Record review of CR #16's nurses notes dated 4/2/2024 at 02:51read in part- Around 12:45am I was giving resident nebulizer treatment and his O2 saturation was 84% with O2 at 2L via n/c. Respiration 28 and labored, BP 143/93, HR 103 and temp 100.3. After 20min nebulizer treatment his respiratory rate continue to decline. While neb treatment going the 200 hall nurse gave me his x-ray result's from off the fax. Impression show subtle patchy opacity (appears as cloudy patches grey area) is seen in both lungs, new, this is likely secondary to pulmonary edema, and atelectasis. Resident O2 sat decline between 80-81 and I called 911. On shift report I was informed resident was having resp distress with hypoxia, hyperglycemia and was to be a direct admit to the hospital (waiting on a bed) to have surgery on his right lower leg distal tibia/fibula fracture. Residents remain hyperglycemic and blood sugar was 424. I called Resident's Physician on call staff and spoke to NP to report his change in condition and he sent 911 . sending him to ER. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #16's clinical records revealed the last MDS assessment on his clinical record was dated 12/21/23 and coded as 5 days assessment. Record review revealed no discharge MDS assessment. CR #44 Record review of Resident #44's Face Sheet dated 08/21/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), muscle weakness, muscle wasting, sepsis (Sepsis is a life-threatening medical emergency caused by your body's overwhelming response to an infection), Record review of CR # 44's clinical records revealed no evidence of discharge MDS. The only MDS on CR #44's clinical record was an admission MDS dated [DATE]. Record review of Physician's discharge summary dated 03/28/24 revealed CR #44 was discharged home in stable condition. Record review of Nurse's note dated 03/29/24 read in part- CR 44's assessment :D\C from facility on 3/29/2024 06:11 . 3/28/2024 6p-6a: Patient was receiving skilled services due to renal failure. The patient was discharged today and left the facility around 0730. He was assisted by his family. He reviewed his inventory and verbally stated that he had all of his belongings. He was informed about his DME that was ordered along with the name and number to the facility to follow up. There were no c/o pain or discomfort when he left. He was escorted out by his wife, and his daughters returned the wheelchair that was used. CR #114 Record review of Resident #114's Face Sheet dated 08/21/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharge on 03/28/24 with diagnoses of lack of communication, lack of coordination, muscle weakness, muscle wasting, and age-related cognitive decline. Record review of Physician discharge orders dated 03/29/24 revealed CR #114 was admitted to the facility on [DATE] and discharged from the facility on 03/28/24 in stable condition. Record review of CR #114' clinical records revealed the last MDS on his clinical record was dated 03/08/24 coded 01-Admission 5 days. The MDS was not completed. Record review revealed no further information on CR #114 clinical records. In an interview on 08/21/24 at 2:51PM, MDS coordinator A looked at CR #4, #16 and #114's clinical records and said the MDS were not done. She did not give any answer why they were not done. She said she would close out the three identified clinical records and submit them to CMS as required. She said those three close records were overlooked. She said not closing out discharge resident's records may give false census. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the facility's DON and Administrator on 08/21/24 at 4:00PM, both the Administrator and the DON said they expect all discharged residents to have their records closed out as expected by regulation. The DON said not closing out the MDS may affect their staffing rating on PBJ report by not providing accurate census. Record review of CMS's RAI version 3.0 Manual dated October 2019 revealed the following: The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). Record review of undated facility's policy and procedure titled Resident Assessment Instrument revealed no information on completing and encoding resident's information into CMS system.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observations, interviews, and record review the facility failed to conduct initial and periodical and comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 4 (Residents #4, #7, #34, & #97) of 16 residents reviewed for accuracy of resident assessments. -Residents #4 was not assessed for her mental diagnoses condition on her Admission MDS dated [DATE] MDS. -Resident # 4 was not accurately assessed for her hearing difficulty on her comprehensive MDS dated [DATE] and on her Quarterly MDS dated [DATE]. -Residents #7 was not assessed for her mental illness and her oral cavity on her annual comprehensive MDS assessment dated [DATE]. -Resident #34 was not assessed for her mental diagnoses. -Resident # 97 was not accurately assessed for he her oral cavity on her annual comprehensive assessment dated [DATE] These failures could place residents at risk of not receiving the care needed to maintain their highest, practicable, physical, social, and psychosocial level of well-being. Findings included: Resident # 4 Record review of Resident #4's electronic face sheet dated 08/19/24 revealed [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Her diagnoses included bipolar disorder, muscle weakness, unspecific dementia, muscle weakness, lack of coordination, difficulty in walking, anxiety disorder, major depressive disorders. Record review of Resident #4's comprehensive admission MDS assessment dated [DATE] revealed Resident #4 had a BIMs score of 11 indicated she was moderately impaired on cognition. Review of section on hearing, she was assessed as adequate with no difficulty in normal conversation. Section on PASRR evaluation was coded as 0, serious mental illness condition was left blank. Section on hearing, was coded she was assessed as adequate. Record review of active diagnoses indicated she was as checked for bipolar disorder. Record review of Resident #4's quarterly MDS assessment dated [DATE] section on hearing was coded as adequate on hearing no difficulty in normal conversation. Record review of Resident # 4's PASRR assessment screening dated 03/13/24 indicated that Resident #4 was positive for mental illness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Nurse's note dated 8/12/2024 10:58 read in part Audiology appointment on 8/16/24 @ 1:45pm for hearing test @ ENT Appointment @ 4:15pm in same building and location. Transportation pick up has been set up with local EMS @ 12:45 pm in wheelchair r/p notified Observation and interview on 08/18/24 at 10:30 AM indicated Resident #4 was in bed alert and oriented. In an interview Resident # 4 started saying she could not hear. A pen and paper were used for communication. She said her ears are blocked and was told that she had ear wax that prevent her from hearing. She said she was supposed to see an audiologist, but her appointment was canceled and re-scheduled. She said she has this problem from time to time and would have her ears cleaned out. She said it had been for a while. In an interview with CNA L on 08/21/24 at 2:00PM, she said Resident # 4 has difficulty hearing. She said she had to speak very loud for her to hear. She said it has been going on for a while. In an interview with LVN E on 08/19/24 at 12:00PM, she said Resident #4 had difficulty hearing. She said Resident #4 had an audiology appointment but was canceled and rescheduled for the week of 08/22/24. She said does not know why the first appointment was cancelled. Resident # 7 Record review of Resident #7's electronic face sheet dated 08/19/24 revealed [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Her diagnoses included neoplasm of colon (colon cancer) chronic pain, bipolar disorder, mood disorder, schizoaffective disorder, (a mental health condition that is marked symptoms, such as hallucinations and delusions, and mood disorder. Hallucinations involve seeing things or hearing voices that others don't observe. delusions involve believing things that are not real or not true) major depressive disorder, essential hypertension, and anxiety disorder. Record review of Resident #7's annual MDS dated [DATE] revealed she was coded as having a BIMS score of 10 which indicated she was moderately impaired on cognition section on mental illness serious mental illness was left blank. Record review of section L Dental was marked as none of the above which indicated no problem on her oral cavity. Record review of Resident # 7's PASRR assessment screening dated 04/17/2023 indicated that Resident #7 was positive for mental illness. She was evaluated for services on 05/04/23 and did not qualify for PASRR services. Observation and interview on 08/18/24 at 1:15 AM, revealed resident #7 was in bed alert and oriented. Observation revealed she was having her lunch. She said her lunch was alright, but she had pain in her gum from her teeth, and she can only eat soft food. She said 4 of her teeth had been pulled and she need to see a dentist. She said the facility was aware and the social worker had to schedule the appointment. During an interview with the facility's social worker on 08/19/24 at 2:00 pm, she said she does not do section L of the MDS, but she would refer resident's for needed services. She said Resident #7 was schedule for dental appointment on the next visit. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with MDS coordinator B on 08/20/24 at 2:00 PM, she looked at the MDS and said she was new to the MDS and was still learning the process. Resident # 34 Record review of Resident #34's electronic face sheet dated 08/19/24 revealed [AGE] year-old female admitted on [DATE]. Her diagnoses included chronic respiratory failure, bipolar disorder, depression, anxiety disorder, mood disorder, Huntington's disease, lack of coordination, difficulty in walking. Record review of Resident #34's comprehensive annual MDS assessment dated [DATE] revealed Resident #34 had a BIMS score of 3 indicated she was severely impaired on cognition. Review of section on active diagnoses indicated she was checked for Huntington disease; bipolar disorder was left blank. Section on PASRR evaluation was coded as 0, serious mental illness condition was left blank. Record review of Resident # 34's diagnoses, indicated she was diagnosed with bipolar disorder on 02/11/2014. Observation on 08/18/24 at 11:00am revealed she was in bed, awake, alert. Attempt was made to communicate but she did not answer; She looked at surveyor. Resident was noncommunicative. She was on tube feeding at 60cc per hour jeverty 1.5, water flush 50cc per hour. During an interview with MDS coordinator A on 08/20/21 at 10:00AM, she looked at the MDS and said she did not do Resident #34's annual MDS assessment. Resident #34 was denied for PASRR services, but the MDS should have identified her mental diagnoses of mental illness. She said not identifying her condition may delay services. Resident # 97 Record review of Resident #97's electronic face sheet dated 08/19/24- revealed [AGE] year-old female admitted on [DATE]. Her diagnoses included disturbance in tooth formation, major depressive disorder, dementia, difficulty walking, lack of coordination, difficulty in walking. Record review of Resident #97's comprehensive annual MDS assessment dated [DATE] revealed Resident #97 had a BIMS score of 10 indicated she was moderately impaired on cognition. Review of section L oral dental indicated she had no problem on her oral cavity. Section was coded O. Observation and interview on 08/18/24 at 10:45AM, revealed Resident # 97 was in bed, alert and oriented. In an interview, she said she was worried about her dentures. She said she left them in the bathroom because they don't fit and cannot use them. She said she has been waiting for a call from the dentist but never got the call. She said the dentist had worked on them before. She said she does not remember how long ago. Observation revealed her dentures were in a cup in the bathroom. Observation and interview on 08/19/24 at 1:20PM, revealed Resident # 97 was served hamburger meat patty, mash potatoes and steamed\cooked cabbage. Resident #97 did not eat the served meal. In an interview she said she cannot eat the meat. LVN G asked resident #97 if she would like an alternative. Resident #97 requested for cottage cheese and fruits. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the facility's social worker on 08/19/24 at 2:00 pm, she said she does not do section L of the MDS, but she would refer all residents for needed services. She said Resident #7 was schedule for dental appointment on the next visit. She said Resident #97 was seen by the dentist and her dentures are being adjusted and she would follow up. Record review of Resident #97's clinical records revealed resident # 97 was seen by the dentist on 03/13/24, 04/10/24 and the last visit was 05/01/24. During an interview with the facility's Administrator and the DON on 08/21/24 at 5:00PM, both said the MDS staff are responsible for ensuring that all assessments reflected Resident's condition. The DON said inaccurate assessment may delay needed services and care. Record review of facility's provided undated policy on resident assessment read in part: Resident Assessment Instrument: Policy Statement A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. Policy Interpretation and Implementation 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: a. Within fourteen (14) days of the resident's admission to the facility; b. When there has been a significant change in the resident's condition; c. At least quarterly; and d. Once every twelve (12) months. 3 The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4 Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40249 Based on observation, interview and record review, the facility failed to ensure comprehensive resident centered care plans were reviewed and revised by the interdisciplinary team after each assessment for 7 residents reviewed for care plan accuracy (Residents #4, # 7, #10, #13, #48, #53, #70). -The facility failed to revise and update Resident #4's care plan to include her cognitive loss, dementia, mental illness of bipolar disorder, communication, and dental care that were triggered on her admission MDS assessment dated [DATE]. - Resident #7 care plan was not updated for cognitive function, visual Function, Psychosocial well-being and activities that were triggered on her annual MDS dated [DATE] -Resident #7's care plan was not updated to include her oral\dental care. --Resident #48's care plan was not updated to reflect DNR status. --Resident #13's care plan was not updated to reflect level of ADL care required. --Resident #48's care plan was not updated to reflect level of ADL care required. --Resident #53's care plan was not updated to reflect level of ADL care required. --Resident #10 order for brace/splint on in morning and removed at night in her record was not implemented. These failures placed residents at risk of not having their needs met and not receiving appropriate individualized care. Findings include: Resident # 4 Record review of Resident #4's electronic face sheet dated 08/19/24 revealed [AGE] year-old fe02/10 and readmitted on [DATE]. Her diagnoses included bipolar disorder, muscle weakness, unspecific dementia, muscle weakness and lack of coordination, anxiety disorder. Major depressive disorders, lack of coordination and difficulty in walking. Record review of Resident #4's comprehensive admission MDS assessment revealed assessment revealed Resident #4 had a BIMs score of 11 indicated she was moderately impaired on cognition. Record review of Resident # 4's care plan dated 07/12/24 revealed her care plan did not include her cognitive loss, dementia, communication, and dental care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 08/18/24 at 10:30 AM indicated Resident #4 was in bed alert and oriented. In an interview Resident # 4 started saying she could not hear. A pen and paper were used for communication. She said her ears are blocked and was told that she had ear wax that prevent her from hearing. She said she was supposed to see an audiologist, but her appointment was canceled and re-scheduled. She said she has this problem from time to time and would have her ears cleaned out. She said it had been for a while. Resident # 7 Record review of Resident #7's electronic face sheet dated 08/19/24 revealed [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Her diagnoses included neoplasm of colon (colon cancer) chronic pain, bipolar disorder, mood disorder, schizoaffective disorder, (a mental health condition that is marked symptoms, such as hallucinations and delusions, and mood disorder. Hallucinations involve seeing things or hearing voices that others don't observe. delusions involve believing things that are not real or not true) major depressive disorder, essential hypertension, and anxiety disorder. Record review of Resident #7's annual MDS dated [DATE] revealed she was coded having a BIMs score of 10 which indicated she was moderately impaired on cognition. Record review of section V CAAs revealed the following area were triggered, Cognitive function, Visual Function, Psychosocial well-being and activities. Record review of Resident # 7's care plan updated 07/29/24 reveal no evidence of care plan for Cognitive function, Visual Function, dental and falls. Observation and interview on 08/18/24 at 1:15 PM, revealed resident #7 was in bed alert and oriented. Observation revealed she was having her lunch. She said her lunch was alright, but she had pain in her gum from her teeth, and she can only eat soft food. She said 4 of her teeth had been pulled and she needed to see a dentist. She said the facility was aware and the social worker had to schedule the appointment. Resident #48 Record review of Resident #48's face sheet revealed admitted [DATE], with diagnoses including Alzheimer's disease (progressive disease that affects memory, thinking, behaviors), psychosis (mental disorder causing disconnection from reality), major depressive disorder (mood disturbance with delusions or hallucinations), chronic obstructive pulmonary disease (lung disease causing breathing problems), hypertension (high blood pressure), liver disease. Advanced Directives on the face sheet stated DNR. Record review of Resident #48's MDS dated [DATE] revealed Resident #48 was rarely or never understood, understands sometimes; has memory problems and moderately impaired cognitive skills; displays inattention and disorganized thinking; and is dependent on staff assistance for all ADLs. Observation of Resident #48 on 8/18/24 at 9:30 am revealed she was in her room, sitting in an easy chair inside her doorway. She appeared confused and not able to follow or answer questions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN H on 8/18/24 at 9:45 am revealed Resident #48 was usually confused, and they helped her with cleaning her up, changing her briefs, showers and dressing, and bring her tray to her in her room so she could eat. She said they check on her about every 2 hours to see if she needed to be changed. Record review of Resident #48's progress note dated 7/24/24 revealed DNR was signed on that date. Record review of Resident #48's undated care plan revealed Resident is Full Code Status with start date of 7/13/24. Interventions included attempt to resuscitate should arrest occur. Resident # 13 Record review of Resident #13's face sheet revealed admitted [DATE] with diagnoses including acute kidney failure (inability of kidneys to filter waste), Diabetes (high blood glucose), cerebral infarction (blockage of blood flow to the brain), hypertension (high blood pressure). Record review of Resident # 13's MDS dated [DATE] revealed a BIMS score of 14, indicating no impairment of cognitive skills; physical impairment of upper and lower extremities on 1 side; dependent on staff assistance for toileting; maximum staff assistance for shower/bathing and dressing; and supervision by staff for hygiene. Observation of Resident #13 on 8/18/24 at 10:20 am revealed she was in bed, talking to her roommate. She said the staff will come help her when she pushes the call light, but sometimes she has to wait until they are finished with someone else. Record review of undated care plan for Resident #13 revealed will receive assistance as needed with ADL's daily. The interventions included assess for barriers to progress, encourage frequent rest periods, but did not include the level of assistance needed for ADL's. Resident #53 Record review of Resident #53's face sheet revealed admitted [DATE] with diagnoses including Dementia ((loss of cognitive functioning), diabetes (increased blood glucose), spinal stenosis (narrowing of the space around spinal cord), muscle wasting and atrophy (loss of skeletal muscle mass). Observation of resident #53 on 8/18/24 at 9:55 am revealed he was in bed and said the staff would come help him when he pushed the call light, and he said they were fast to answer the light and help with whatever he needed. Record review of Resident #53's MDS dated [DATE] revealed BIMS score of 11, indicating moderately impaired cognitive skills, dependent on staff assistance with ADL's (total assistance needed). Record review of Resident #53's undated care plan revealed Requires assistance with all ADL's. Interventions included assess barriers to progress, give verbal cues to help prompt, break tasks into smaller steps, but interventions did not include level of assistance required. Resident #74 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #74's face sheet revealed admitted [DATE] with diagnoses including Parkinsonism (brain condition causing slow movements, stiffness and tremors), hypertension (high blood pressure), Dementia (loss of cognitive functioning), psychotic disorder (mental disorder causing disconnection from reality), history of falling. In an interview with MDS Coordinator A on 8/20/24 at 12:40 pm, she said the ADL assistance levels should be on the care plan, and if it was not there, it was missed. She said she would update the care plans as needed with information from the team. She said the risk of not having accurate care plans would affect the resident by the CNA not knowing the proper care for the residents. In an interview with the Administrator and DON on 8/21/24 at 5:30 pm, they said the care plans should be accurate for the resident's care, and the risk of not having an accurate care plan would be the residents would not receive proper care. Resident#10 Record review of Resident #10's annual MDS assessment, dated 07/06/24, reflected a [AGE] year-old female with an admitted [DATE] and was readmitted on [DATE]. Her diagnoses included acute cystitis without hematuria (sudden inflammation of the bladder caused by a bacterial infection, also known as a urinary tract infection), cerebrovascular disease (stroke, brain aneurysms and cerebral arteriovenous/blood clots) and lack of coordination due hemiplegia (one-sided muscle paralysis or weakness). Record review of Resident #10's consolidated physician orders for 4/4/24 Brace/Splint: Apply to the Left foot on during the day and off @ HS (Hour of sleep) for diagnosis left side foot drop QD (every day). Chart refusals every morning and at bedtime related to Hemiplegia, affecting left dominant side. Record review of Resident #10's annual MDS dated [DATE] revealed she had a BIMS score of 11/15 (moderately cognitively intact) and diagnosis of hemiplegia. Record review of Resident #10's Care Plan dated 4/11/2024 revealed she had applied brace/splint to the left foot as ordered. She required extensive assistance of one-to-two-persons with all ADLs. Record review of Resident #10's medication administration record (MAR) dated 08/01/24 had nurses initialed as done for Brace/splint: Apply to the Left foot on during the day (at 9:00 AM) and off @ HS (Hour of sleep at 9:00 PM) for diagnosis left side foot drop QD (every day). Chart refusals every morning and at bedtime related to Hemiplegia, affecting left dominant side. There was no document reflecting resident #10's refusal of brace/splint to left foot. Observation on 8/20/24 at 9:29 AM, 11:00 AM, 2:00 PM, 4:00 PM Resident #10 did not have Brace/Splint to left side foot drop, she was lying in bed and there was no brace/splint at bedside. Interview on 8/20/24 at 4:00 PM with Resident #10 said she had not had any brace/splint on. Observation on 8/21/24 at 10:39AM, 11:00 AM, 2:00 PM, 4:00 PM, Resident #10 did not have Brace/Splint to left side foot drop. Interview on 8/21/24 at 2:00PM with Resident #10, she said she had never had any brace/splint on. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN KK on 08/21/24 at 2:00 PM regarding Resident #10's Brace/Splint to left side foot drop not being on the resident, she said Resident #10 did not have the brace /splint on her bedside. LVN KK said she did not receive any report about resident #10 using Brace/Splint to left side foot drop and she had not worked with the resident for a while. Interview on 8/21/2024 at 4:30 PM with the DON, she stated she was not aware residents were getting Brace/Splint to left side foot drop. The DON expected the staff to follow physician orders and care plans. The DON said Resident #10 always refused the Brace/Splint to left side foot drop. In an interview on 08/21/24 at 5:15 PM the DON stated the facility did not have a policy specifically for drop foot management. The DON did not have policy for following physician's order. Record review of the facility policy Care Plans - Comprehensive, undated, revealed, in part: . assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change .the Care Planning/Interdisciplinary team is responsible for the review and updating of care plans .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review the facility failed to ensure residents with limited range of motion received appropriate treatment and services to prevent a decline in range of motion for 1 (Resident #10) of 17 residents. The facility failed to ensure Resident #10 had interventions in place for her left side foot drop (difficulty lifting the front part of the foot) using the brace/splint to foot can help hold the foot in a normal position. This deficient practice placed residents at risk for decrease in mobility, range of motion, and could contribute to worsening of foot drop. Findings Include: Record review of Resident #10's annual MDS assessment, dated 07/06/24, reflected a [AGE] year-old female with an admitted [DATE] and was readmitted [DATE]. Her diagnoses included acute cystitis without hematuria (sudden inflammation of the bladder caused by a bacterial infection, also known as a urinary tract infection), cerebrovascular disease (stroke, brain aneurysms and cerebral arteriovenous/blood clots) and lack of coordination due hemiplegia (one-sided muscle paralysis or weakness). Record review of Resident #10's consolidated physician orders for 4/4/24 Brace/Splint: Apply to the Left foot on during the day and off @ HS (hour of sleep) for diagnosis left side foot drop QD (every day). Chart refusals every morning and at bedtime related to Hemiplegia, affecting left dominant side. Record review of Resident #10's annual MDS dated [DATE] revealed she had a BIMS score of 11/15 (moderately cognitively intact) and diagnosis of hemiplegia. Record review of Resident #10's Care Plan dated 4/11/2024 revealed apply brace/splint to the left foot as ordered. She required extensive assistance of one-to-two-persons with all ADLs. Record review of Resident #10's recommendation from the Physical therapy Nursing Restorative Care Program dated 4/2/24 approaches and frequency. RNA (Restorative Nurse Aide) to provide bilateral upper extremities exercises with TheraBand or exercise bike for 10-15 minutes . Left PROM exercises as needed. Observation on 8/20/24 at 9:29 AM, 11:00 AM, 2:00 PM, 4:00 PM Resident #10 did not have Brace/Splint to left side foot drop, she was lying in bed and there was no brace/splint at bedside. Interview on 8/20/24 at 4:00 PM with Resident #10 said she had not had any brace/splint on Observation on 8/21/24 at 10:39AM, 11:00 AM, 2:00 PM, 4:00 PM Resident #10 did not have Brace/Splint to left side foot drop. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/21/24 at 2:00PM with Resident #10, she said she had never had any brace/splint on. Interview on 8/21/2024 at 1:55 PM with the RNA (Restorative Nurse Aide) she said works with Resident #10 on the bike exercise and TheraBand and Resident #10 always refuse brace/splint and the licensed nurse place the splint. Record review of Resident #10's Resident #10's RNA and TARs no documentation of Brace/Splint to left side foot drop refusal and restorative care was initiated since 4/2/24. In an interview with LVN KK on 08/21/24 at 2:00 PM regarding Resident #10's Brace/Splint to left side foot drop not on resident, she said Resident #10 did not have the brace /splint on her bedside. LVN KK said she did not receive any report about resident #10 using Brace/Splint to be left side foot drop and she had not worked with the resident for a while. Interview on 8/21/2024 at 4:30 PM with the DON, she stated she was not aware residents were getting Brace/Splint to left side foot drop. The DON expected the staff to follow physician order and care plan. DON said Resident #10 always refused the Brace/Splint to left side foot drop. In an interview on 08/21/24 at 5:15 PM the DON stated the facility did not have a policy specifically for drop foot management. DON did not have policy for following physician's order.

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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 a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one (Resident #10) of two residents reviewed for incontinence care. -The facility failed to ensure CNA BB provided appropriate perineal care for Resident #10 after an incontinent episode when she failed to open and clean the labia. -The facility failed to ensure CNA BB cleaned and wiped around the resident's buttocks after an incontinent episode . These failures could place residents at risk for the development and/or worsening of urinary tract infections and skin breakdown. Findings include: Record review of Resident #10's annual MDS assessment, dated 07/06/24, reflected a [AGE] year-old female with an admitted [DATE] and was readmitted [DATE]. Her diagnoses included acute cystitis without hematuria (sudden inflammation of the bladder caused by a bacterial infection, also known as a urinary tract infection), cerebrovascular disease (stroke, brain aneurysms and cerebral arteriovenous/blood clots), muscle wasting and atrophy, not elsewhere, right lower leg, bacteremia, adult failure to thrive, acute candidiasis (fungal/yeast)of vulva and vagina, sepsis, non-pressure chronic ulcer of skin of other sites with fat layer exposed, pressure ulcer of right buttock, stage 4, type 2 , mellitus (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly, causing blood sugar levels to rise) without complications, age-related nuclear cataract, bilateral, heart failure, lack of coordination due hemiplegia (one-sided muscle paralysis or weakness). Resident #10 had a BIMS of 11, which indicated she was moderately cognitively impaired. She required extensive assistance of one-to-two-persons with all ADLs and was always incontinent of bowel and bladder. Record review of Resident #10's care plan, dated 3/31/24, reflected, . The resident has an ADL self-care deficit .Interventions .Personal hygiene and Toilet use- Resident is totally dependent (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 08/20/24 at 09:29 a.m. revealed CNA BB entered Resident #10's room preparing to provide incontinence care. CNA BB washed her hands and put on double gloves and unfastened Resident #10's brief soiled with urine and had large bowel movement. CNA BB took a peri-wipe and cleaned residents' perineal area; she did not open the labia to wipe. CNA BB assisted the resident to roll on her left side. CNA BB took a peri-wipe and wiped in-between residents' rectal area and did not wipe around the buttocks. With the same gloves, CNA BB applied barrier cream to a chafed area on the residents' right buttocks and then removed the soiled brief and placed a clean brief under the resident and assisted her to roll back onto her back and fastened the brief. CNA BB removed her gloves and washed her hands. Review of CNA BB's skill checks dated 07/29/24 reflected she was competent in performing peri-care and hand hygiene. In an interview with CNA BB on 08/20/24 at 10:15 a.m. she stated she was supposed to wash her hands before and after performing incontinent care and change her gloves when she finished. She stated she was supposed to open the labia to clean and around the buttocks. She stated she knew the importance of properly cleaning a resident and by not doing so, placed them a risk of infections. In an interview with the DON on 08/21/24 at 02:00 p.m., she stated staff were to open labia and clean around residents' buttocks. She stated by not following proper peri care it placed residents at risk of urinary tract infections. Record review of the facility's policy titled, Perineal care, revised October 2010, reflected, .Wash and dry hands thoroughly .put on gloves .wash perineal are, wiping from front to back .Separate labia and wash area downward from front to back . Assist the resident to turn on her side .Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks .Rinse and dry thoroughly

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40249 Based on observation, interview, and record review the facility failed to ensure expired drugs were removed from the medication room used to store drugs and biologicals in accordance with currently accepted professional principles when applicable for 1 of 1 medication room, 4 of 7 medication carts observed for labeling and storage of drugs and biologicals. The facility failed to ensure expired medications stored in the medication storage room were removed and disposed according to facility procedures for drug destruction and drugs open were dated. This deficient practice could place residents who receive medications from the medication room at risk for receiving outdated medications and could result in residents not getting the intended therapeutic effects of their medications and worsening of residents' symptoms. Findings include: During observation on 08/20/24 at 1:30 PM, the following expired medications were found in the medication room with RN EE: 1. Meclizine Chewable 7 bottles 100 tablets expired 06/24 2. Prenatal for women before, during and after pregnancy 100 tablet multivitamin and mineral dietary supplement expired 6/24. 3. Optimum vitamin A 3,000 mcg 100 soft gel 3 bottles expired 4/24 4. Calcium 600 +D 5mcg 60 tablets 1 bottle expired 11/23. 5. Calcium 600 +D 5mcg 60 tablets 8 bottles expired 4/24 6. Enema saline laxative 1 4.5 Fl.oz expired 3/24 7. Sore throat spray (Cherry Flavor) 6 Fl.oz expired 5/24 8. Docusate Calcium (Stool softener) 100 softgels 240 mg each 7 bottles expired 4/24 Interview with RN EE on 8/20/24 at 1:55 PM, she said she was not sure who checks the medication room and she think it might be supply stock person. 600 Hall Medication cart. During observation on 08/20/24 at 2:05 PM, the following expired medications were found in the 600 Hall medication cart and medication open not dated with RN EE 1. Earache drops open not dated (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Haloperidol con 2 mg /ml pen not dated 3 Lantus Solostar pen (3ml) open not dated 4. Famotidine tab 20 mg expired 4/24 5. Ammonium Lactate lotion 12% open not dated 6. Ammonium Lactate lotion 12% open not dated Interview with RN EE on 8/20/24 at 2:05 PM she was asked how often she checks the cart for expired medications. She said she just came back to work, she was off duty for1 month. Observation at 2:14 PM on 8/20/24 after showing RN EE the above expired medication and some opened not dated medications, RN EE said medication opened should be dated. 400 Hall Medication cart. During observation on 08/20/24 at 2:30 PM, the following expired medication were found in the 400 Hall medication cart with LVN AA 1. Triple antibiotic ointment 1oz expired 10/23. Interview with on 08/20/24 at 2:30 PM with LVN AA, she said she checks her medication cart whenever she works and she started working with the facility in 1/24. 100 Hall Medication cart During observation on 08/20/24 at 2:34 PM, the following nasal spray medication open and not dated were found in the 100 Hall medication cart with MA H 1. Fluticasone Propionate 50 mcg per spray open not dated 2. Fluticasone Propionate 50 mcg per spray for open not dated. 200 hall Medication cart. Levetiracetam oral solution 473ml open not dated Antacid Calcium Carbonate 750 mg 96 chewable tablets expired 2/2024 Interview with MA AA on 8/20/24 at 2:34 PM she said she works 2:00 pm to 10:00 pm and she checks her medication cart weekly or every 2 weeks. The following medication were taken in the morning and should have been dated when opened. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 8/21/2024 at 11:27 PM, with the DON and the unit Managers, the DON stated the expired medications were supposed to be removed and kept in the designated area for expired drugs to be destroyed and the nurses were responsible for checking their medication cart. The DON stated this deficient practice could affect residents because the expired drugs could be mistakenly given to resident and would not be treating the symptoms it was supposed to treat. Residents could have GI (gastrointestinal) problem if they ingest expired drug. Interview with Administrator and DON, RN on 8/21/24 at 11:27 AM they both said, the nurses were responsible for checking the medication carts for expired medication. The pharmacist checks medication cart also, and was in the facility a couple of weeks ago. The managers were assigned to each medication carts weekly. They said central supply clerk checks the medication room., The DON said the central supply clerk was newly hired and was on vacation. Their expectation was managers were over medication carts and they did 100% audit on all medication on 8/20/24. The Nurse Managers will be checking medication cart weekly.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent (5%) or greater. The facility had a medication error rate of 14.28%, based on 4 errors out of 28 opportunities, which involved 1 of 4 residents (Resident #93), and 1 of 4 staff (Medication Aide DD) reviewed for medication errors. -Medication Aide DD failed to administer 4 medications Ferrous Sulfate Tab EC 325 MG (iron supplement used to treat or prevent low blood levels of iron), Cholecalciferol Tab 50 MCG (2000 Unit) (a fat-soluble vitamin that helps your body absorb calcium and phosphorus), Gabapentin Cap 100 MG (used to treat epilepsy. It's also taken for nerve pain, which can be caused by different conditions) and Carbamazepine Tab 200 MG (an anticonvulsant. It works by decreasing nerve impulses that cause seizures and nerve pain, such as trigeminal neuralgia and diabetic neuropathy) to Resident #93 according to physician orders. This failure could place residents at risk for not receiving therapeutic effects of their prescribed medications and possible adverse reactions. Finding include: Record review of the Admission Sheet (undated) for Resident #93reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #93 diagnosis included dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures) and dementia (a group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #93's Quarterly MDS, dated [DATE] reflected a BIMS score 09 out of 15 indicating moderately impaired cognition. Resident #93 was dependent on staff for personal hygiene, putting on/taking off footwear, shower/bathe self and toileting hygiene. Record review of Resident #93's Care Plan initiated 11/16/2022 and revised on 10/20/2023 reflected the following: Category: Seizures Goal: Will minimize risk for seizure activity daily and ongoing over the next 90 days. Intervention: levetiracetam, lacosamide and carbamazepine as ordered. Observation on 08/19/24 beginning 7:45am during med pass revealed MA DD prepared, dispensed, and administered 13 medications to Resident #93. The medications observed were: - Aspirin Tab Delayed Release 81MG Give 1 tablet orally one time a day related to Unspecified sequelae of cerebral infarction (I69.30) Give 1 tablet orally one time a day. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lactulose (Encephalopathy)Solution 10 GM/15ML Give 30 ml by mouth one time a day related to epilepsy, unspecified, not intractable, without status epilepticus (G40.909) Give 30 ml by mouth one time a day. -Lisinopril Tab 5 MG Give 1 tablet orally one time a day related to Essential (primary) hypertension (I10) Give 1 tablet orally one time a day, (hold for sbp<110 or dbp<60) -Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) Give 2 scoop orally one time a day related to Chronic idiopathic constipation (K59.04) Give 2 scoop orally one time a day. -Carbamazepine Tab 200 MG Give 2 tablet orally two times a day related to Epilepsy, unsp, notintractable, without statusepilepticus (G40.909) Give 2 tablet orally two times a day -Famotidine Tab 20 MG Give 1 tablet orally two times a day related to Unsp fx shaft of humerus, left arm, subs for fx w routn heal (S42.302D) Give 1 tablet orally two times a day -Levetiracetam Tab 1000 MG Give 1 tablet by mouth two times a day related to Other seizures (G40.89) Give 1 tablet by mouth two times a day. -Levetiracetam Tab 500 MG Give 1 tablet by mouth two times a day related to Other seizures (G40.89) Give 1 tablet by mouth two times daily -Magnesium Oxide Oral Tablet 250MG (Magnesium Oxide) Give 1 tablet by mouth two times a day related to Hypomagnesemia (E83.42) Give 1 tablet by mouth two times a day. -Memantine HCl Tab 5 MG Give 1 tablet by mouth two times a day related to gastroesophageal reflux disease without esophagitis (K21.9) Give 1 tablet by mouth two times a day. -Sertraline HCl Tab 50 MG Give 1 tablet orally one time a day related to Major depressive disorder, recurrent, mild (F33.0) Give 1 tablet orally one time a day. -Baclofen Tab 20 MG Give 1 tablet orally four times a day related to Epilepsy, unsp, not intractable, without status epilepticus (G40.909) Give 1 tablet orally four times a day. -Pantoprazole Sodium EC Tab 40 MG (Base Equiv) Give 1 tablet orally every 12 hours related to Nausea with vomiting, unspecified (R11.2) Give 1 tablet orally every 12 hours. Once MA DD indicated to Surveyor, she had completed Resident #93's medication administration for the scheduled 8am medications, further observation reflected MA DD failed to administer 4 prescribed medications as ordered. 1) Ferrous Sulfate Tab EC 325 MG (65 MG Fe Equivalent) Give 1 tablet orally one time a day related to Epilepsy, unsp, not intractable, without status epilepticus (G40.909) Give 1 tablet orally one time a day. 2) Cholecalciferol Tab 50 MCG (2000 Unit) Give 1 tablet orally one time a day related to Epilepsy, unsp, not intractable, without status epilepticus (G40.909) Give 1 tablet orally one time a day. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Gabapentin Cap 100 MG Give 1 tablet orally three times a day related to Unsp fx shaft of humerus, left arm, subs for fx w routn heal (S42.302D) Give 1 tablet orally three times a day. 4) Carbamazepine Tab 200 MG Give 2 tablet orally two times a day related to Epilepsy, unsp, notintractable, without status epilepticus (G40.909) Give 2 tablet orally two times a day. Administered 1 tablet instead of 2 tablets as ordered. Record review of Resident #93's MAR for August 19, 2024 revealed MA DD documented that Resident #93 was administered the following medications: Ferrous Sulfate Tab EC 325 MG (65 MG Fe Equivalent) Give 1 tablet orally one time a day related to Epilepsy, unsp, not intractable, without status epilepticus (G40.909) Give 1 tablet orally one time a day. Cholecalciferol Tab 50 MCG (2000 Unit) Give 1 tablet orally one time a day related to Epilepsy, unsp, not intractable, without status epilepticus (G40.909) Give 1 tablet orally one time a day. Gabapentin Cap 100 MG Give 1 tablet orally three times a day related to Unsp fx shaft of humerus, left arm, subs for fx w routn heal (S42.302D) Give 1 tablet orally three times a day. These medications were not observed being administered during med pass 8/19/24 beginning at 7:45a.m. Record review of Resident #93's nurse's notes for August 2024, reflected no documented evidence found that the doctor was notified of the missed doses on August 19, 2024 for the medications prescribed. In an interview on 8/19/24 at 10:37a.m., MA DD stated the medications were scheduled to be administered at 8 AM and she could have a grace of 1 hour prior and 1 hour post 8 AM to administer medications safely. MA DD stated she went down the list and documented that she administered the medications without looking at the name of the medication today (8/19/24) before moving to next resident for med pass. The surveyor reviewed med pass observation from earlier 8/19/24 beginning at 7:45 am and reviewed Resident #93's MAR with MA DD. MA DD stated, I forgot to give iron and D3 both were over the counter. MA DD stated Gabapentin Cap 100 MG was not available on the cart or in the overflow. She stated she faxed to the pharmacy for it to be delivered today. MA DD stated she remembered giving Carbamazepine Tab 200 MG it was a big white pill but I gave 1 instead of 2. When asked what could happened if resident missed dose of prescribed medication. MA DD stated, nothing would happen if missed one day. In an interview on 8/19/24 at 1:22p.m., the DON and the Administrator, the DON stated the expectation was for medications to be administered as ordered by the physician and standards of practice. The DON stated the risk to residents could have been a possible reduction in therapeutic efficacy of the medications. The DON stated iron could affect hemoglobin., D3 was supplement and gabapentin was to treat pain. She stated Medication Aide had their competency check off upon hire and annually. The DON stated gabapentin was in pyxis (an automated medication dispensing system). The DON stated MA DD did not have access to pyxis but she could let the nurse know to pull and administer. In an interview on 8/19/24 at 3:16p.m., with LVN E, she stated gabapentin 100mg and 300mg were available in the pyxis. She stated MA DD did not notify her of Resident#93 missed medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676153	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of League City	2620 W Walker League City, TX 77573

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Competency Assessment Administering Oral Medications (not dated) revealed read in part: .A) Purpose: The purpose of this procedure is to provide guidelines for the safe administration of oral medications. E) Steps in the Procedure: 6. Check 1he label on the medication and confirm 1he medication name and dose with the MAR. 8. Check the medication dose, Re-check to confirm the proper dose . Record review of facility's Administering Medications policy (not dated) revealed read in part: . Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Verifying/Identifying Resident/Medication: 6. The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method of administration before giving the medication. Documentation of Medication: 12. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones .

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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 did not maintain an infection prevention program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 4 Staff (CNA BB) reviewed for infection control. The facility failed to ensure CNA BB followed proper hand hygiene during incontinent. These deficient practices could affect residents and place them at risk for infection, and reinfection. Findings include: Record review of Resident #10"s annual MDS assessment, dated 07/06/24, reflected a [AGE] year-old female with an admitted [DATE] and was readmitted on [DATE]. Her diagnoses included acute cystitis without hematuria (sudden inflammation of the bladder caused by a bacterial infection, also known as a urinary tract infection), cerebrovascular disease (stroke, brain aneurysms and cerebral arteriovenous/blood clots) and lack of coordination due hemiplegia (one-sided muscle paralysis or weakness). Record review of Resident #10's annual MDS dated [DATE] revealed she had a BIMS score of 11/15 (moderately cognitively intact). She required extensive assistance of one-to-two-persons with all ADLs and was always incontinent of bowel and bladder. Record review of Resident #10's care plan, dated 3/31/24, reflected, . The resident has an ADL self-care deficit .Interventions .Personal hygiene and Toilet use- Resident is totally dependent An observation on 08/20/24 at 09:29 a.m. revealed CNA BB entered Resident #10's room preparing to provide incontinence care. CNA BB washed her hands and put on double gloves, she picked up Kleenex from the floor and discarded it in the trash, did not change gloves, using the same gloved hands, picked up the clean wipes from the container on the bedside table and unfastened Resident #10's brief soiled with urine and had large bowel movement, CNA BB assisted the resident to roll on her left side. CNA BB took a peri-wipe and wiped in-between residents' rectal area and did not wipe around the buttocks. With the same gloves, CNA BB applied barrier cream to a chafed area on the resident buttocks and then removed the soiled brief and placed a clean brief under the resident and assisted her to roll back onto her back and fastened the brief. CNA BB removed her gloves and washed her hands. Review of CNA BB's skill checks dated 07/29/24 reflected she was competent in performing peri-care and hand hygiene. In an interview with CNA BB on 08/20/24 at 10:15 a.m. she stated she was supposed to wash her hands before and after performing incontinent care and change her gloves when she finished. She stated she knew the importance of properly cleaning a resident and by not doing so, placed them a risk of infections. (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 with DON on 08/21/24 at 02:00 p.m., the DON said CNA BB should wash or sanitize her hands when soiled and she should not use double gloves. The DON said CNA BB would be retrained before working with incontinent residents. Record review of the facility's policy titled Handwashing/Hand Hygiene (revised October of 2010) revealed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; Or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a residence intact skin; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections.