STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676161	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for 2 of 7 residents (Residents #3 and #7) reviewed for feeding tubes. RN G failed to ensure Resident # 3's enteral feeding formula and water bag was labeled with the date and time of administration via G tube (feeding tube medical device to provide nutrition) on 09/25/2024. RN A failed to ensure Resident #7's enteral feeding formula and water bag was labeled with the date and time of administration via G tube (feeding tube medical device to provide nutrition) on 09/25/2024. The facility failed to ensure Resident # 3's and Resident #7's enteral feeding piston syringe was stored in container and dated on 09/25/2024. These failures could place residents at risk of tube obstruction and a decrease in hydration. Findings included: In an observation on 09/25/24 at 11:25 AM of Resident #3's enteral feeding system revealed that her G tube enteral feeding formula bag and H20 Bag was not labeled with the date of administration and the piston syringe was lying in a clear container undated. In an attempted interview on 09/25/24 at 11:25 AM with Resident #3 was unsuccessful due to a communication deficit. Record review of Resident #3's undated face sheet reflected a [AGE] year-old female with and admitted [DATE]. DX included: Huntington disease (genetic brain disease), dysphagia (difficulty swallowing). (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's admission MDS assessment, dated 08/19/24, reflected Resident #3 had BIMS score of 0 which indicated she was severely cognitively impaired. She was depended on staff for hygiene and ADL care. She was and always incontinent of bowel and bladder and she received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Record review of Resident #3's care plan with a revision date of 07/01/24 reflected, . [Resident #3] require PEG feeding .Interventions .Provide tube feeding and water flush as ordered . Resident has an ADL self-care performance deficit r/t Disease Process Huntington disease (impaired balance) . she has limited physical mobility r/t Disease process of Huntington .Resident has a communication problem r/t unable to get words out r/t Huntington Record review of Resident #3's Physician orders 09/02/24 reflected Enteral Feed (method of feeding through a device) Order every 4 hours Manually flush .feeding tube with 50 cc water every 6 hours .dated 8/23/24 Enteral Feed Order every night shift Change feeding .Enteral Feed Order every night shift cleanse G-tube stoma (opening in the body) with soap/water Q D. Record review of Resident #3's Medication administration record for August 2024 reflected, .Flush G-tube with 60 ml of H2O before and after meds TID . with a start date of 03/01/23. In an observation on 09/25/24 at 11:50 AM of Resident #7's revealed her enteral feeding system was unplugged, and the formula and water bag were not dated. The piston syringe (a small pump device used to flush tubing out with water after medication and enteral feeding) was placed on top of a white towel stored in a pink bed pan unbagged or dated. The G tube enteral feeding formula bag and H20 bag were not labeled with the date and time of administration. In an interview Resident #7 on 09/25/24 at 11:45 AM, she stated that the nurse (name unknown) placed the syringe on the towel in the pink bed pan on her bedside table. Resident #7 stated that the syringe was not placed in a container. Record review of Resident #7's undated face sheet reflected a [AGE] year-old female with and admitted [DATE]. Diagnoses abdominal aortic aneurysm (enlarged aortic vessel), coronary artery disease (heart disease), ischemic cardiomyopathy, Barrett's esophagus (abnormal change in sells lining lower portion of the esophagus), GERD, esophageal (food pipe that runs between the throat and stomach. Cancer (disease involving abnormal cell growth). Record review of Resident #7's admission MDS assessment, dated 08/30/24, reflected Resident #7 had BIMS score of 15 which indicated she was intact cognitively. She was totally depended on all ADL and always incontinent of bowel and bladder and she received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Record review of Resident #7's care plan with a revision date of 07/01/24 reflected, . [Resident #3] require PEG (medical procedures when a tube passed into a patient's stomach through the abdominal wall.) feeding . Interventions .Provide tube feeding and water flush as ordered . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's Physician orders 09/02/24 reflected Enteral Feed Order every 4 hours Manually flush .feeding tube with 50 cc (cubic Centimeters) water every 6 hours .dated 8/23/24 Enteral Feed Order every night shift Change feeding .Enteral Feed Order every night shift cleanse G-tube phone stoma with soap/water Q (every) D (day). In an interview on 09/25/24 at 2:30 PM with RN A who stated she observed the piston syringe and formula bags not being labeled with dates. She was very busy and did not replace and discard when found. She said the risk to the resident would be contamination. Formula and water should be labeled with the date, time, and name of nurse completing the task. The syringe should be placed in a container and dated to prevent overuse of syringe. In an interview on 09/25/24 at 2:05 PM with RN A who stated that she has been employed at the facility for one year. She said during lunch rounds she observed Resident #3's enteral feeding formula bag and water bag undated. RN A said she forgot to return and change. RN A said the piston tubing should be dated when feeding system was installed. The syringe was used to flush the after each feeding. Once used, it should be cleaned, dried, and stored in a dated container. RN A said the formula bag and H20 were labeled with the date, time, rate, and person administrating the feeding. She said Resident #3'the overnight nurse-initiated s enteral feeding. She could not remember her name. She said the risk of not dating and storing properly could result in an overuse of the syringe and infections. In an interview on 09/25/24 at 2:20 PM with RN G who stated the night nurse (10:00 PM-6:00 AM) initiated the enteral feeding for Resident #7 today. The previous nurse (name not provided) told her that she dated and labeled the feeding supplies. RN G said the piston syringe was observed on a white towel inside of a pink bed pan on the resident bedside table. RN G said she believed it was Resident #7's preference to store the syringe in that manner, however she did not ask the resident if it was her preference, nor did she educate the resident on infection control and sanitation protocol if this was her preference. RN G said she was the charge nurse conducting care rounds from 7:00 AM-3:00 PM today, and it was the nurse's responsibility to observe and inspect the feeding supplies to ensure it was dated and labeled according with nursing services. She said failing to label and date the items (formula, water, piston syringe) could result in cross contamination. the syringe was found stored improperly and update, it should have been replaced, dated, and placed in a container to prevent contamination. In an interview on 09/26/24 at 10:22 AM with ADON who stated it was her expectation for the charge nurse are responsible for resident care and treatment task during their shift. She stated that the enteral feeding system every two hours during rounds or as needed during resident care rounds. The nurse should be checking to ensure the equipment was labeled with the date and time on the formula, water, rate of feeding, and sign to communicate the necessary information for each shift. She expects the piston syringe to be cleaned, dried, and stored in a clear container or original packaging and dated, as the syringes are sued for 24 hours before discarding. She stated that failing to label could result in infections, contamination, and sepsis. In an interview on 09/26/24 at 10:44 AM with DON who stated that all parts of the enteral feeding supplies should be labeled with the date and time so that clinical staff will know when the task was completed. She expects the charge nurse to check the system every two hours during resident care rounds. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/26/24 @ 10:55 AM with ADM who stated he expected the nursing staff to conduct regular rounds to ensure the equipment was working and labeled according to their policy to prevent resident illnesses. Record review of facility In-service dated 09/25/24 by DON did not reflect the time of training. In-service training report reflected a Title Labels for tube feeding The tube feeding containers and tubing are to have date, time, initials, when you change them. Tube feeding syringes are to be changed daily and have a date initial on bags-keep in bags! LVN L, RN G, and RN A signatures were on the sign in sheet for the in-service. Record review of the facility's Policy and Procedure titled Enteral Feeding-Safety Precautions .dated October 22 and reviewed January 23 . reflected Purpose: To ensure the safe administration of enteral nutrition. Preparation: All personnel responsible for preparing, storing, and administering enteral nutrition formula will be trained, qualified and competent in his or her responsibilities The facility will remain current in and follow accepted best practices in enteral nutrition. General Guidelines: Preventing contamination Administration changes: Change administration sets for open-system enteral feedings at least every 24 hours, or as specified by the manufacturer . Change administration sets for closed-system enteral feedings according to manufacturer's instructions. Preventing errors in administration: check Resident name, ID and room number, type of formula, date, and time the formula was prepared; route of delivery; on the formula label document initials, date, and time the formula was hung, and initial the label was checked against the order. Preventing aspiration: Check enteral tube placement every 4 hours and prior to feeding or administration of medication Elevate the head of the bed (HOB) at least 30 during tube feeding and at least 1 hour after feeding .Monitor for signs and symptoms of respiratory distress during enteral feedings and medication administration. Preventing mis-connection errors: Ensure that all enteral formula labels indicate Not for IV (intravenous therapy is a medical technique that administers fluids, medications, nutrients directly into the persons vein) Use. Instruct all all-non-clinical staff, residents, and visitors not to reconnect any tubing or lines, but instead to notify a nurse if tubing becomes disconnected .Regularly inspect tubing for proper and secure connections.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observations, interviews, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for one (Resident #4, #5, and #6) of 3 residents reviewed for respiratory therapy. 1. LVN L failed to ensure Resident, #5 and #6's NC were changed and dated according to facility policy on 09/25/24. 2. RN A failed to change, date, and store Resident #4's NC tubing and nebulizer mask in a dated bag when on 09/25/24. These failures could lead to respiratory infections, poor air quality, and not having their respiratory requirements met. Findings included: In an observation of Resident #4 on 09/25/24 at 11:40 AM and 09/26/24 at 10:00 AM revealed she was lying on her back with the HOB (head of bed) raised with her NC (nasal cannula) positioned in her nose. The oxygen concentrator was powered on and the humidifier water bottle was undated. Further observation revealed the nebulizer machine and O2 mask was on the nightstand with other personal items (tissue, wipes) unbagged and undated (stored improperly). The resident was not using the machine on (09/17/24 and 09/18/24). Resident was a little confused and stated she was not experiencing any discomfort or breathing difficulties. She could not remember who or when the last time she used the nebulizer machine. Record review of Resident #4 face sheet dated 09/25/24 reflected she was a [AGE] year-old female admitted on [DATE] with current DX: Dementia, Unspecified Severity (decline in memory), Without Behavioral Disturbance, Psychotic Disturbance Mood Disturbance, (mental health delusions, paranoia), and Anxiety (worry and fear). Record review of resident #4's quarterly MDS dated [DATE] reflected a BIMS score of 3, indicating she was severely impaired cognitively. Resident # 4 was dependent on staff for all ADL's. Additional information indicated she was being treated for anxiety, dementia, and oxygen (see initial comments) and they were addressed on the MDS. Record review of resident #4's Care Plan dated 09/25/24 reflected she had a diagnosis of congested heart failure interventions monitor/document/report PRN any s/sx of CHF. SOB upon exertion, weakness, wheezing (whistle sound) .Oxygen settings: O2 via NC @ 2LM for O2 Sats .90 % .impairment cognitive function/dementia impaired thought process r/t (related to). interventions included Keep residents' routine consistent and try to provide consistent care givers as much as possible. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's MD orders dated 02/28/24 reflected 02 at 2 liters per minute .via nasal cannula continuously. May titrate to 3-4 LPM to keep 02 sats >90% every shift for 02 sat >90% - order dated 02/28/24 change nebulizer treatment tubing Q week very night shift every Sunday .order dated 02/28/24 Change, label/date O2 tubing weekly every night shift every Sunday . ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally two times a day for Congestion/SOB . order date 03/01/24 Check O2 sat every shift. Record review of Resident #4's September 2024's TAR reflected charting for tubing change on 09/22/24 and nebulizer treatment on 9/24/24 PM and 9/25/24 AM. Resident #4's reflected daily O2 checks on each shift by nursing staff. In an observation of Resident #5 on 09/25/24 at 11:43 AM revealed resident nebulizer mask lying on a chair next to the bed face down unbagged and undated. The resident was observed in the hallway immediately after with NC in her nose connected to portable oxygen attached to her wheelchair. The tubing was not dated. In an observation on 09/26/24 at 10:03 AM revealed Resident #5's nebulizer mask bagged and dated, and NC tubing dated 09/26/24. Record review of Resident #5 face sheet dated 09/25/24 reflected she was an [AGE] year-old female admitted on [DATE] with current DX: Dementia (memory decline), Asthma (inflamed airways of the lungs), COPD (chronic lung disease) Disturbance, Psychotic disturbance Mood Disturbance, (mental health delusions, paranoia), and Anxiety (worry and fear). Record review of resident #5's quarterly MDS dated [DATE] reflected BIMS score of 12 indicating she was cognitively intact. Resident #5's was dependent on staff for ADL"s. Resident #5's MDS did not address oxygen treatment in Section O. Record review of resident #5's Care Plan dated 07/16/24 reflected The resident has limited physical mobility related to weakness .Resident #5 has impaired cognitive function or impaired thought process related to Dementia. Interventions included Communicate with the resident/family/caregivers regarding resident capabilities and needs .Resident #5 has depression r/t dementia. Intervention included monitor for signs and symptoms of depression .Resident #5 has oxygen therapy r/t ineffective gas exchange .interventions monitor respirations, pulse, cough, confusion . Resident #5 has asthma r/t COPD .interventions . Educate resident/family/caregivers regarding resident reflected overuse of inhalers, stress, s/sx of impending asthma attack: coughing, decreased energy, and asthma triggers .Resident #5 has altered respiratory status/difficulty breathing r/t COPD .interventions monitor for s/sx of respiratory distress and report to MD, administer medications /puffers as ordered and monitor effectiveness and side effects. Record review of Resident #5's MD orders dated 04/09/23 reflected Change, label/date O2 tubing weekly every night shift every Sunday. Order date 05/24/22 Symbicort Aerosol 160-4.5 MCG (Micrograms)ACT (Asthma control test) (Budesonide Formoterol Fumarate) .2 puff inhale orally two times a day related to chronic obstructive pulmonary disease, unspecified (J44.9) Wait 30-60 seconds between puffs. Rinse mouth afterwards. Order date 07/18/22 Change/label/date O2 tubing weakly every night shift every Sunday .Check O2 sat every shift for O2 sat . order dated 05/23/22 O2 at 2 liters per minute .via nasal cannula continuously. May titrate to 3-4 LPM to keep 02 via nasal cannula continuously. May titrate to 3-4 LPM to keep O2 sats >90%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5's September TAR reflected tubing changes on 09/22/24 and nebulizer treatment on 9/24/24 PM and 9/25/24 AM. Resident #4's reflected daily O2 checks on every shift. In an observation of Resident #6 on 09/25/24 at 11:45 AM resident lying in bed on her back with NC in her nose undated. Resident #6's concentrator bottle and NC it was not dated. Resident #6's oxygen concentrator was powered on. In an observation of Resident #6 on 09/26/24 revealed resident asleep in her bed on her back and concentrator bottle and NC was dated 09/26/24. Resident #6's oxygen concentrator was powered on. Record review of Resident #6's face sheet dated 09/26/24 reflected she was an [AGE] year-old female admitted initially on 10/05/22 and readmitted on [DATE] with diagnosis of Unspecified dementia (memory decline), Mood disturbance and anxiety (fear and worry of unknown), and chronic respiratory failure with hypoxia (abnormal levels of oxygen in the body). Record review of resident #6's quarterly MDS dated [DATE] reflected she had a BIMS score of 8 indicating she was moderately cognitive impaired .Mood, depression, anxiety. She was dependent on staff for ADL care, and she received oxygen therapy. Record review of resident #6's Care Plan dated 09/11/24 reflected the resident was at risk for re-hospitalization related to COPD .interventions observed for changes and levels of consciousness . Resident has behaviors related to Dementia .interventions included positive interactions by caregivers monitor behaviors, behaviors of verbally aggression r/t dementia. Resident #6 has impaired cognitive functioning/dementia/or impaired thought process . Resident has Emphysema/COPD r/t smoking. 1 the resident has oxygen therapy r/t Ineffective gas exchange Maintain 02 at 3 LPM (liters per minute) continuously to keep 02 >92% monitor for s/sx of respiratory distress and report to MD. Change label/dated O2 tubing weekly every night shift .O2 at 2 LPM (liters per minute) via nasal cannula. In an interview on 09/25/24 at 2:15 PM with LVN L who stated that it was the responsibility of the night staff nurse that worked on Sunday's 10:00 PM to 6:00 AM to change all resident tubing and mask every Sunday. She said ongoing monitoring by the charge nurse each shift during care rounds to ensure tubing was stored properly when not in use and dated. She said tubing found undated or stored outside the bag should be changed and dated immediately. Nebulizer mask should be bagged and dated. LVN L said the said overuse of mask and tubing could result in illnesses and infections. She said resident tubing and mask that were not in use should be stored in a bag and dated until next use. When asked about the yellow color on the NC prongs of Resident #5 , she stated that some NC supplies have a blue or yellow color on the prongs. She nor the ADM provided the supplies to confirm that the yellow prong tips were provided in package. upon delivery. In an interview with the ADON on 09/26/24 at 10:22 AM who stated it was the nursing staff's responsibility to check tubing during rounds. ADON said tubing found undated, on the floor, soiled .should be removed immediately, discarded, then re-install and date with a new tubing or mask. She expects the nursing staff to change the tubing as need and weekly. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 09/26/24 at 10:44 AM who stated that she expected the nursing staff to conduct rounds checking oxygen levels, oxygen flow, tubing for dates, and stored in a plastic dated bag when not in use. The DON stated she and the ADON were responsible for monitoring to ensure the orders were followed. The DON stated the tubing and humidifiers on the oxygen concentrators were no longer required to have an order to change tubing weekly. All tubing was as needed. In an interview on 09/26/24 at 10:55 AM with the ADM who said the DON, RN G, LVN L, and RN A told him that that there was a new protocol for oxygen tubing that does not require weekly orders to change tubing. The ADM expected the staff to follow current policy and changing weekly and as needed. He said tubing should be dated to confirm date it was changed. Record review of facility In-service dated 09/25/24 by DON did not reflect the time of training. In-service training report reflected a Title Labels for Oxygen Oxygen tubing is to be changed when soiled, when on the ground, and when discolored. Date and initial when done. LVN L and RN A signatures were listed on the sign in sheet for the in-service. Record review of facility policy titled Oxygen Administration dated Revised and Reviewed May 2024 reflected Oxygen Administration .Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation .Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed .General Guidelines Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter .The oxygen mask is a device that fits over the resident's nose and mouth. It is held in place by an elastic band placed around the resident's head .The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose.Check the mask, tank, humidifying jar, etc. (Used at the end of a list to indicate that further similar items are included. to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. Cannula/Mask needs changed if it malfunctions or becomes visibly contaminated .Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: The date and time that the procedure was performed .The name and title of the individual who performed the procedure .The rate of oxygen flow, route, and rationale .The frequency and duration of the treatment .The reason for P.R.N . (As needed) administration .The signature and title of the person recording the data .Reporting: Notify the supervisor if the resident refuses the procedure .Report other information in accordance with facility policy and professional standards of practice.