STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER: Rambling Oaks Courtyard Extensive Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 112 Barnett Blvd, Highland Village, TX 75077	

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 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** 45055 Based on observations, interviews, and record review, the facility failed to ensure that assessments accurately reflected the resident's status for one (Resident #5) of eight residents reviewed for Accuracy of Assessments. The facility failed to ensure Resident #5's Comprehensive MDS Assessment accurately reflected that Resident #5 had an impairment to her right upper extremity. This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. Findings included: Review of Resident #5's Face Sheet, dated 10/16/2024, revealed the resident was an [AGE] year-old female admitted on [DATE]. One of the relevant diagnosis was unspecified joint contracture (tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Review of Resident #5's Comprehensive MDS Assessment, dated 08/16/2024, revealed the resident was unable to complete the interview to determine the BIMS score. Section GG - Functional Abilities and Goals GG0115, dated 08/16/2024, revealed Resident #5 had no impairment to the upper extremity. According to Section GG, upper extremity was constituted by the shoulder, elbow, wrist, and hand. Review of Resident #5's Comprehensive Care Plan, dated 09/23/2024, reflected the resident had limited physical mobility and the goal was the resident would be free from complications related to immobility including contractures and skin breakdown. Review of Resident #5's Physician's Order, dated 08/15/2024, reflected Soft towel rolled inside right palm during day shift and off at HS. Every shift for contracture off at night. Observation on 10/16/2023 at 9:17 AM revealed LVN E was about to administer Resident #5's medication. She said she would first reposition the resident, who was lying on her right side, before giving the medications. LVN E rolled the resident to a flat position, with the head of the bed elevated. It was observed that the right hand of the resident had a contracture and was clutching a towel. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN E on 10/17/2024 at 7:14 AM, LVN E said Resident #5 had a contracture to her right hand. She said the lower extremities were always bended but the resident could straighten them if the resident wanted to. Observation and interview with the MDS Nurse on 10/17/2024 at 7:27 AM, the MDS Nurse stated the MDS should reflect the current status of the resident. She said the functional status must reflect if the resident had any impairment or not. The MDS Nurse said she would base her assessment on the documentation and what she saw. She said the care plan was also based on the assessments. The MDS Nurse logged on to her computer and looked for the resident's profile. The MDS Nurse checked on the functional status of the resident and saw that the resident's MDS did not reflect any impairment. She said she was not sure if the resident's contracture would be considered as an impairment. She said when she assessed the upper extremities, she would observe if the resident could move the arm from the shoulder. She said she would ask her superior to know if the contracture to the right hand was considered as an impairment. Interview with the MDS Nurse on 10/17/2024 at 7:40 AM, the MDS Nurse said the resident's contracted right hand was considered as an impairment. She said she would be doing an in-service with the Administrator and she would audit those residents with contractures and modify their MDS. She said an accurate MDS was important because it would be the basis of the care needed by the resident. If the assessment was not accurate, the current status of the resident would not be correct resulting to confusion in her care. This could also result in the resident not getting the appropriate care needed. In an interview with CNA D on 10/17/2024 at 8:10 AM, CNA D stated Resident #5 could not use her hands because they were tight, especially the right hand. CNA D said he had been in the facility for almost two and a half years and had seen Resident #5's right hand to be contracted. He said the only treatment for the right hand was to put a rolled towel inside the hand. In an interview with PT F on 10/17/2024 at 8:17 AM, PT F stated a contracture was considered an impairment because due to the tightening of the muscles, there was a loss of function. PT F said Resident #5's contracted hand could be considered as an impairment. She said a soft towel was placed inside the resident's hand to prevent it from excoriation (abrasion of the skin's surface). In an interview with the DON on 10/17/2024 at 8:24 AM, the DON stated the MDS should reflect the actual functionality of the resident. She said if the resident had an impairment, it should have been assessed correctly and mirrored on the MDS. If the residents were not properly assessed, the proper care and needs would not be met. The DON said the expectation was the residents were properly assessed not only during admission but every day to see if there was a change in condition, any refusal of care, or resident acting different than usual. She said she would coordinate with the MDS Nurse to do an audit of the MDS Assessments. In an interview with the ADON on 10/17/2024 at 8:33 AM, the ADON stated if there were impairments to the upper extremity and lower extremity, the MDS should have a record of it. ADON said there should be proper communication between the staff to ensure proper assessments were done. If there was no accurate assessment, there could be a confusion about the care needed by the resident. She said she would coordinate with the DON and the MDS Nurse on how to address the issue. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 10/17/2024 at 8:55 AM, the Administrator stated accurate assessments should be done to know what kind of care and services would be required. He said if the assessment was not accurate, the needed care of the resident would not be met. He said the expectation was the residents would be assessed accurately to provide the appropriate care needed. He said he would coordinate with the DON and the MDS Nurse to check the MDS, not only of the residents with contractures, but of all the residents. Record review of facility policy, Comprehensive Assessments 2001 MED-PASS, Inc. revised October 2023 revealed Policy Statement: Comprehensive MDS assessments are conducted to assist in developing person-centered care plans . Policy Interpretation and Implementation . 1. The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity.

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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** 45055 Based on observations, 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 set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for one (Resident #13) of eight residents reviewed for Care Plans. The facility failed to ensure Resident #13 was care planned for her colostomy (Opening in the belly done surgically to create a new passageway for feces. One end of the large intestine would be redirected out of the abdominal wall and a colostomy bag would be in place to catch the feces). This failure could place the residents at risk of not receiving the necessary care and services needed. Findings included: Review of Resident #13's Face Sheet, dated 10/16/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #13 was diagnosed with systemic lupus erythematous (chronic disease that could cause inflammation and pain). Review of Resident #13's Comprehensive MDS Assessment, dated 09/20/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. Resident #13's Comprehensive MDS Assessment indicated the resident had an ostomy (opening in the abdomen). Review of Resident #13's Comprehensive Care Plan on 09/04/2024 reflected there was no care plan for colostomy care. Review of Resident #13's Physician Order, dated 12/17/2024, reflected change ostomy bag 2 x weekly on Mondays and Thursdays and prn. Observation and interview with Resident #13 on 10/15/2024 at 9:10 AM, Resident #13 was in her bed, awake. She said she had a colostomy bag and the nurse was the one emptying it. She said she did not want it but her doctor said she might have for a long time. Resident #13 raised her hospital gown to show her colostomy bag. Observation and interview with LVN A on 10/16/2024 at 12:11 PM, LVN A stated Resident #13 had a colostomy bag and she would empty it several times during her shift. After asking permission from the resident, LVN A lifted the resident's gown to show the resident's colostomy bag located on the resident's lower left quadrant of the abdomen. The colostomy bag was empty. After showing the colostomy bag, LVN A went to her cart and looked for the resident's care plan for colostomy. She said there was no care plan for colostomy. She said the care plan was important so the staff taking care of the resident would be in sync with the level of care being provided. She said without the care plan for the colostomy, required care might be missed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with the MDS Nurse on 10/17/2024 at 7:27 AM, the MDS Nurse stated she was not the only staff responsible for doing the care plan. She said the DON and the ADON also did the care plans. She said the care plan for Resident #13's colostomy bag was missed during their IDT (Interdisciplinary Team) meeting. She said the care plan was dependent on the resident's disease process, assessment, and the doctor's orders. She said the care plan should reflect the medications they were taking and the required services they were receiving. She said without the care plan, there could be lapse on the care needed and the staff would not know how to properly care for the resident's colostomy. The MDS Nurse opened the resident's profile and saw that a care plan was already in place. The care plan was created 10/16/2024. In an interview with the DON on 10/17/2024 at 8:24 AM, the DON stated every resident needed a comprehensive care plan to make sure the residents received the proper care needed. The DON said the care plan should be in place so that the staff providing care would be on the same page. The DON stated the care plan was important because it reflected the resident's problem lists, goals, and intervention. She said the care plan should be resident-centered and should show what specific care the resident needed. She said the care plan for Resident # 13's colostomy had been rectified when it was brought to her attention. She said the expectation was for all residents to have a complete and detailed care plan. She said she would coordinate with the MDS Nurse to audit for resident's the care plans of the resident. In an interview with the ADON on 10/17/2024 at 8:33 AM, the ADON stated if a resident had a colostomy, there should be a care plan for the care of the colostomy. She said the care plan was a snapshot of what was supposed to be done for the resident, as well as the services provided. She said without the care plan, the staff would not be in sync on the care of the residents and their needs would not be addressed. She said the expectation was all the issue of the residents were care planned. In an interview with the Administrator on 10/17/2024 at 8:55 AM, the Administrator stated the care plans were important to ensure the residents were getting the care needed. He said care plans served as guides on how the staff would take care of the residents. The Administrator said without the care plans, the level of care needed could be missed. The Administrator said the expectation was for the staff to ensure the residents were care planned accordingly. He said he would coordinate with the DON and the MDS Nurse to make sure all the residents were care planned. Record review of facility policy, Care Plans, Comprehensive Person-Centered 2001 MED-PASS, Inc. revised March 2022 revealed 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 . 7 .The comprehensive, person-centered care plan . e. reflects currently recognized standards of practice for problem areas and conditions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on interviews and record reviews, the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Residents #25) of 6 residents reviewed for (ADL) care provided to dependent residents. The facility failed to ensure Resident #25 received scheduled bed baths according to reviews from October 1, 2024 - October 16, 2024. This failure placed the resident at risk of not receiving necessary services to maintain good personal hygiene and decreased self- esteem. Findings included: Record review of Resident #25's Face Sheet, dated 10/17/2024, revealed she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included Parkinson's disease (memory loss) and bed confinement. Record review of Resident #25's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, she had a Brief Interview for Mental Status (BIMS) score of 12 (moderate impairment) and fo,r ADL care it stated, for transfers, toileting, and bathing, the resident required total assistance. Record review of the facility's shower sheet for Resident #25 from 10/01/24 to 10/16/24 reflected a single shower sheet for the resident dated 10/16/2024. In an interview on 10/15/24 at 11:01 AM, Resident #25 complained of not getting her bed baths when scheduled. She stated she was scheduled for her bed baths on Monday, Wednesday, and Friday, but she had not received any so far that month. She stated she preferred bed baths because she does not like the mechanical lift and was happy with her bed baths. She stated she had told a CNA, but they advised her that they were busy and would get back with her, but they never returned. She stated she would like her bed baths because she does not like being dirty. In an interview on 10/17/24 at 12:45 PM, LVN S stated that she knew, for sure, that Resident #25 had received her bed baths when she was scheduled on Monday, Wednesday, and Friday, but she was not sure why there was only one shower sheet recorded for the resident, including the bed bath she had received on 10/16/24. She was advised that the resident stated she had not received her bed baths this month. She stated the risk of the resident not getting her bed baths could result in the resident having skin breakdown, and it was a dignity issue. In an interview on 10/17/24 at 12:45 PM, the ADON stated she was made aware of Resident #25 not having but one shower sheet on file, as of 10/16/24. She stated she was sure that she had received her scheduled bed baths and the CNA probably forgot to complete the shower sheets. She confirmed that CNAs were required to complete shower sheets for all residents, regardless of whether a shower was provided or refused. She stated the risk of the resident not receiving her bed baths could result in skin breakdown, she could have a bad smell, and it was a dignity concern. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/17/24 at 12:54 PM, CNA S stated she had been at the facility a year. She stated she normally did not provide Resident # 25 her scheduled bed baths, but she did provide them at times. She stated she did provide the resident bed baths on Fridays, but she did not know the exact dates. She stated she forgot to complete the shower forms for the resident. She stated staff were supposed to complete showers sheets on every resident, whether they had refused a shower or not. She stated if the resident did not get their showers or bed baths when scheduled, she could have skin breakdown and they could get a fungus. The facility's policy Bath, Shower/Tub (dated February 2018), reflected The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 2 (Resident #12 and #30) of 4 residents reviewed for accident prevention. The facility failed to obtain physician orders or a physician assessment as of 10/15/24 for Residents #12 and #30, for the usage of a scoop mattress prior to installing the mattress to assist in fall prevention. This failure could prevent residents from having an environment that was free and clear of accidents and hazards. Findings included: Record review of Resident #12's Face Sheet, dated 10/16/2024, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included difficulty walking, lack of coordination, and history of falling. Record review of Resident #12's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected, she had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and for ADL care it reflected assistance was required for transfers, toileting, and bathing and the resident was totally dependent for assistance. Record review of Resident #12's physician orders dated 10/16/24 reflected no orders for a scoop mattress and no physician assessment was observed in the facility system records. An observation on 10/15/24 at 11:40 AM of Resident #12's bed revealed she was sleeping on a scoop mattress. The upper and lower sides of the mattress had raised sides of at least 6 inches. Record review of Resident #30's Face Sheet, dated 10/16/2024, reflected she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included muscle weakness, lack of coordination, and moderate risk of falling. Record review of Resident #30's Quarterly Minimum Data Set (MDS) dated [DATE] reflected, she had a Brief Interview for Mental Status (BIMS) score of 10 (moderately impaired cognition), and for ADL care, it reflected assistance was required for transfers, toileting, and bathing. The resident was totally dependent for assistance. Record review of Resident #30's physician orders dated 10/16/24 reflected no orders for a scoop mattress and no physician assessment was observed in the facility system records. An observation on 10/15/24 at 11:25 AM of Resident #30's bed revealed she was sleeping on a scoop mattress. The upper and lower sides of the mattress had raised sides of at least 6 inches. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 10/15/24 at 1:00 PM, LVN S was shown Resident #12 and #30's scoop mattresses and she stated that she thought the residents had orders for the scoop mattress, but she was not sure. She stated if the resident did not have physician orders or an assessment for the scoop mattress, they could injure themselves if they tried to get out of the bed. In an interview and observation on 10/15/24 at 1:00 PM, the ADON was shown resident #12 and #30's scoop mattresses and she stated that the mattresses were considered therapeutic, and she did not think that it required physician orders and a physician assessment. She confirmed that there were no physician assessments completed by the residents' physician. She stated that the risk of the residents' not having their physician assess the risk of using the scoop mattress, could result in the resident's injuring themselves if they attempted to get out of the bed. In an interview on 10/16/24 at 1:00 PM, the DON and Corporate Compliance Nurse was advised of Resident #12 and #30's scoop mattresses and they stated that they thought that the since the mattresses were considered therapeutic, no physician orders or a physician assessment was required. They were advised that the scoop mattress had raised sides on the upper and lower sides of the residents' beds, which was a risk for the residents. The DON confirmed that there were no physician assessments completed by the residents' physician and she stated that the risk of the residents' not having neither could result in the resident's injuring themselves if they attempt to get out of the bed. Review of the facility's policy Medication and Treatment Orders (dated July 2016), reflected Orders for medications and treatments will be consistent with principles of safe and effective order writing.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interview, and record review, the facility failed to ensure residents who needed colostomy care were provided such care, consistent with professional standards of practice for one (Resident #13) of two residents reviewed for Colostomy Care. The facility failed to ensure Resident #13 had physician orders for colostomy (Opening in the belly done surgically to create a new passageway for feces. One end of the large intestine would be redirected out of the abdominal wall and a colostomy bag would be in place to catch the feces) care. This failure could place residents with colostomy at risk for not receiving care or delay in treatment/care due to not having an order. Findings included: Review of Resident #13's Face Sheet, dated 10/16/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #13 was diagnosed with glomerular disease in systemic lupus erythematous (chronic disease that could cause inflammation and pain). Review of Resident #13's Comprehensive MDS Assessment, dated 09/20/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. Resident #13's Comprehensive MDS Assessment indicated the resident had an ostomy (opening in the belly). Review of Resident #13's Comprehensive Care Plan on 09/04/2024 reflected no care plan for colostomy care. Review of Resident #13's Physician Order, dated 12/17/2024, reflected change ostomy bag 2 x weekly on Mondays and Thursdays and prn. Observation and interview with Resident #13 on 10/15/2024 at 9:10 AM, Resident #13 was in her bed, awake. She said she had a colostomy bag and the nurse were the one emptying it. She said she did not want it but her doctor said she might have for a long time. Resident #13 raised her hospital gown to show her colostomy bag. Observation and interview with LVN A on 10/16/2024 at 12:11 PM, LVN A said Resident #13 had a colostomy bag. She said she would empty it several times during her shift. LVN A went to her cart, logged on to her computer, and looked for the resident's orders for colostomy care. she said there were no orders for Resident #13's colostomy except to change to colostomy bag twice a week and PRN. She said there were no orders to empty the colostomy bag every shift or when it was one half full, no order to examine the stoma and the surrounding skin, no order to assess for any ostomy drainage or signs and symptoms of infection, and no order for to check for any leakage. She said there should be an order for the colostomy. She said the orders should be transcribed in the resident's profile. She said she was responsible in putting the order for the resident's colostomy. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 10/17/2024 at 8:24 AM, the DON stated there should be an order for every care and treatment done for the residents. She said without the orders, there could be missed care. She said the orders would provide an outline for the staff on the kind and level of care needed and given. She said the nurse who received the resident during admission should had placed the order. She said she was responsible, as well, in checking if the appropriate orders were in the system. She said the orders for colostomy care were already transcribed when the issue was brought to her attention. She said the expectation would be all the treatment provided had orders. She said she would do an in-service about colostomy care and the need for orders. In an interview with the ADON on 10/17/2024 at 8:33 AM, the ADON stated colostomy care had been provided by nurses because they knew they should be done. She said even though the staff knew what to do, there should still be an order and it should be documented. She said without the order, new staff might not know the treatment and what to assess. She said she would coordinate with the DON regarding re-educating the staff about the need for orders and colostomy care. In an interview with the Administrator on 10/17/2024 at 8:55 AM, the Administrator stated there should be an order specific to the medical condition and needs of the resident. He said there should be orders for the medications, treatment, diet, services, and what to assess. He said without the orders, the probability of missed care would be high. He said the expectation was for the staff would be mindful and check if the orders were placed accordingly. Review of the facility policy Colostomy/Ileostomy Care 2001 MED-PASS, Inc. revised October 2010 revealed Purpose: The purpose of this procedure is to provide guidelines . in preventing exposure of the resident's skin to fecal matter . Steps . 8. When evaluating the condition of the resident's skin, note the following: a. Breaks in the skin . b. Excoriation . c. Signs of infection (heat, swelling, pain, redness, purulent exudate, etc.). Review of the facility policy Medication and Treatment Orders 2001 MED-PASS, Inc. revised July 2016 revealed Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing . Policy Interpretation . orders must be recorded immediately in the resident's chart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Rambling Oaks Courtyard Extensive Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE 112 Barnett Blvd Highland Village, TX 75077	

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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 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** 45055 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Resident #2, Resident #5, and Resident #15) of eight residents reviewed for Respiratory Care. 1. The facility failed to ensure that Resident #2's breathing mask for nebulization was properly stored and his humidifier had water in it. 2. The facility failed to ensure that Resident #5's yankauer suction tip (a firm plastic suction tip used to suction secretions in the mouth) was properly stored. 3. The facility failed to ensure that Resident #15's nasal canula was properly stored in a sanitized container. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #2's Face Sheet, dated 10/16/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #2 was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident #2's Comprehensive MDS Assessment, dated 09/20/2024, reflected the resident was cognitively intact with a BIMS score of 13. Resident #2's Comprehensive MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #2's Comprehensive Care Plan, dated 09/17/2024, reflected the resident had COPD r/t smoking and one of the interventions was give aerosol (medications given through an inhaler) or bronchodilators (medications that dilate the airways) as ordered. Review of Resident #2's Comprehensive Care Plan, dated 09/17/2024, reflected the resident was on oxygen therapy r/t respiratory illness and one of the interventions was to monitor for signs and symptoms of respiratory distress. Review of Resident #2's Physician Order, dated 10/10/2024, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML. 1 vial inhale orally one time a day for Shortness of Breath. Review of Resident #2's Physician Order, dated 10/10/2024, reflected Oxygen at 2 l/m to 4 l/m per nasal cannula as needed for SOB/Respiratory Compromise O2 sats less than _90__% (add percentage). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 10/15/2024 at 9:38 AM revealed Resident #2 was in his bed, awake. The resident was on oxygen therapy via nasal cannula at 3 liters per minute and was connected to an oxygen concentrator. The humidifier bottle on his oxygen concentrator was empty. It was observed that there was tube hanging out on the drawer of the resident's left-side table. The resident said it was okay to open his drawer. Inside the drawer, was a nebulizer with a breathing mask connected to it. The breathing mask was not bagged. The resident said he was given a breathing treatment every morning. He said the nurse would put it on and the nurse would take it off when it was done. He said he was not aware where the nurse would put it after the breathing treatment. He said he did not notice there was no water in his bottle. He said he will tell the nurse to put some water in the bottle. Observation and interview with LVN A on 10/15/2024 at 11:43 AM, LVN A stated she administered Resident #2's breathing treatment every morning. She said after the breathing treatment was done, she should clean it and put it inside a plastic bag to keep it safe. LVN A went inside the room, opened the resident's drawer and saw the breathing mask inside the drawer. LVN A disconnected the breathing mask and said she was going to change it because she was not able to bag it when she took it off the resident. She said the breathing mask should be bagged to prevent cross contamination and respiratory infection. LVN A threw the breathing mask, went out of the room, and returned with a new breathing mask. She said she noticed the resident's humidifier had little water when she gave the resident's medications and planned to come back to fill it up. She said she should have put water in it because it was already low. She said the humidifier would keep the nasal pathway moist to prevent irritation. LVN A took plastic container of distilled water and filled the humidifier halfway. 2. Review of Resident #5's Face Sheet, dated 10/16/2024, revealed the resident was an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with encephalopathy (a disease that affects brain structure or function and usually cause confusion, disorientation, memory loss, and agitation). Review of Resident #5's Comprehensive MDS Assessment, dated 08/16/2024, revealed the resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident was receiving hospice care. Review of Resident #5's Comprehensive Care Plan, dated 09/23/2024, reflected the resident was receiving hospice services and one of the interventions was to provide maximum comfort for the resident. Review of Resident #5's Physician's Order, dated 10/29/2021, reflected Admit to hospice DX: Senile degeneration of the brain. Review of Resident #5's Physician's Order, dated 10/26/2021, reflected May suction as needed. Review of Resident #5's agreement with hospice, dated 11/09/2021, reflected Hospice Responsibilities: . 2. Durable Medical Equipment . suction pump. Observation on 10/15/2024 at 10:16 AM revealed the resident was in her bed, sleeping. It was observed that the resident had a suction machine on top of her right-side table. A yankauer was connected to the suction machine. The yankauer was observed sitting on top of the table and was beneath a plastic container (the yankauer was not properly stored). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN B on 10/15/2024 at 12:51 PM, LVN B stated Resident #5 had a suction machine in case she had a lot of secretions and was unable to spit it out. She said the suction machine was provided by hospice and the main purpose was to maintain the airway patent. She said the resident rarely used it. She went inside the resident's room and saw the yankauer connected to the suction machine was on top of the table. She disconnected the yankauer and threw it on the waste basket. She said she would get a new one because the yankauer was already considered dirty. She said she did not notice the yankauer was just on the table when she was providing care. She said it should be stored properly to avoid germs from going inside the body if it was used. She said she would put it inside a bag while not in use. 3. Review of Resident #15's Face Sheet, dated 10/17/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #15 was diagnosed with acute respiratory failure with hypoxia. Review of Resident #15's Comprehensive MDS Assessment, dated 09/23/2024, reflected the resident was moderately impaired with a BIMS score of 11. Resident #15's Comprehensive MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #15's Comprehensive Care Plan, dated 09/17/2024, reflected the resident was on oxygen therapy r/t respiratory illness and one of the interventions was to monitor for signs and symptoms of respiratory distress. Review of Resident #15's Physician Order, dated 10/17/2024, reflected no physician orders for the oxygen concentrator. An observation on 10/15/24 at 09:36 AM revealed Resident #15's nasal cannula was coiled up on top of the resident's bed and not in a sealed container. An interview and observation on 10/15/24 at 09:40 AM, LVN S was shown Resident #15's nasal cannula coiled up on the resident's bed and not in a sealed container. She stated that the resident used the oxygen concentrator on an as needed basis, and she was not sure why it was sitting on the resident's bed and not placed in a sealed container. She stated the risk of not placing the nasal cannula in a bag when not in use, could result in the resident getting an infection. In an interview with the DON on 10/17/2024 at 8:24 AM, the DON stated the nasal cannula, breathing mask, and the yankauer should be stored properly when not in use to keep them clean. She said if those breathing apparatuses were not bagged, were exposed, or touching surfaces that were not clean, there could be cross contamination, respiratory infection, and oxygen administration could be compromised. She said the expectation was for the staff to be mindful in making sure that the nasal cannula, breathing mask, and the yankauer were properly stored. She said the nasal cannula, breathing mask, and the yankauer should be cleaned before storing them. She said the humidifier should always have water in it to prevent drying of the nose and the throat. She said the staff should refill it as soon as they saw it because they never knew when they could come back to the resident's room to put water in the humidifier. She said moving forward, she would make an in-service and re-educate the staff about storing the breathing mask and the yankauer properly to provide a quality and professional care. She said she would follow-up with that issue personally. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rambling Oaks Courtyard Extensive Care Community	112 Barnett Blvd Highland Village, TX 75077

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADON on 10/17/2024 at 8:33 AM, the ADON stated the nasal cannula, breathing mask, and the yankauer should be bagged when not in use. She said not bagging them could result in cross contamination and respiratory infection. She said even though the policy would only say to bag the nasal cannula, the policy also applies to the breathing mask and the yankauer. She said the purpose of the humidifier was to moisten the nasal pathway to improve comfort and prevent irritation. She said the expectation was for the staff to bag all the respiratory apparatuses used by the residents when not in use. She said she would coordinate with the DON pertaining to education and in-services about respiratory care. She said she would include checking on the respiratory apparatuses being bagged during her walk around. In an interview with the Administrator on 10/17/2024 at 8:55 AM, the Administrator stated everything that the residents were using should be kept clean to prevent infection. He said he was not a clinician but would coordinate with the DON on how to go forward about the issue of respiratory care. He said the expectation was for the staff to be trained proficiently, follow basic protocols, and ask if something needed clarification. He said they would monitor the staff and discuss the issue. Record review of facility's policy, Oxygen Administration 2001 MED-PASS, Inc. revised October 2010 revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration . 12 . 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. Record review of facility's policy, Departmental (Respiratory Therapy) - Prevention of Infection MED-PASS, Inc. revised November 2011 revealed Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy . Steps . 8. Keep the oxygen cannula and tubing . in a plastic bag when not in use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45055 Based on observations, interviews, and record review, the facility failed to ensure the medications for four (Resident #1, Resident #13, Resident #14, and Resident #35) of fifteen residents were provided a safe and secured storage with limited access. 1. The facility failed to ensure Resident 1's zinc oxide (ointment used to prevent skin irritation), Miralax, eye drops , and a nasal spray were not left on top of the resident's left side table. 2. The facility failed to ensure Resident 13's stoma powder was not left on top of the resident's left side table. 3. The facility failed to ensure Resident 14's zinc oxide was not left on top of the resident's left side table. 4. The facility failed to ensure Resident 35's zinc oxide was not left on top of the resident's TV stand. These failures could place the residents at risk of not receiving medications, accidental overdose, or misuse of medications. Findings included: 1. Review of Resident #1's Face Sheet, dated 10/16/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #1 was diagnosed with metabolic encephalopathy (a disease that affects brain structure or function and usually cause confusion, disorientation, memory loss, and agitation). Review of Resident #1's Comprehensive MDS Assessment, dated 09/05/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment also indicated the resident had medically complex conditions. Review of Resident #1's Comprehensive Care Plan, dated 09/23/2024, reflected the resident had impaired cognitive function or impaired thought processes noted due to her metabolic encephalopathy and the intervention was to report any changes in cognitive function. Observation on 10/15/2024 at 11:40 AM revealed the resident was in her bed, sleeping. There were several medications on the resident left side table. The medication were zinc oxide (ointment used to prevent skin irritation), Miralax, refresh eye drops, and fluticasone nasal spray. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN B on 10/16/2024 at 9:51 AM, LVN B said medications should not be left on top of the resident's side table because somebody could accidently ingest it. She said somebody confused or allergic to the said medications might use it. She said those medications were brought by one of resident's family member. She said she would tell the resident's family member that she would put the medications somewhere with limited access. LVN B took the medications and placed them inside the drawer of the resident's left side table. 2. Review of Resident #13's Face Sheet, dated 10/16/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #13 was diagnosed with glomerular disease in systemic lupus erythematous (chronic disease that could cause inflammation and pain). Review of Resident #13's Comprehensive MDS Assessment, dated 09/20/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. Resident #13's Comprehensive MDS Assessment indicated the resident had an ostomy (opening in the abdomen). Review of Resident #13's Comprehensive Care Plan on 09/04/2024 reflected no care plan for colostomy care. Review of Resident #13's Physician Order, dated 12/17/2024, reflected change ostomy bag 2 x weekly on Mondays and Thursdays and prn. Observation and interview with Resident #13 on 10/15/2024 at 9:10 AM, Resident #13 was in her bed, awake. She said she had a colostomy bag and the nurse would change it periodically. Resident #13 raised her hospital gown to show her colostomy bag. It was observed that there was plastic container of stoma powder on the resident's left side table. Observation and interview with LVN A on 10/15/2024 at 12:11 PM, LVN A stated Resident #13 had a colostomy bag and it was changed weekly. She said the stoma powder was used as a skin protector to prevent stoma-related complications. She said it should not be left on the table or anywhere accessible to other residents and visitors. She said it could be accidently ingested and children could mistake it for candies. LVN A took the stoma powder and placed it in the resident's drawer along with the other paraphernalia for colostomy care. 3. Review of Resident #14's Face Sheet, dated 10/17/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #14 was diagnosed with ulcerative proctitis (inflammation of the lining of the rectum) and altered mental status. Review of Resident #14's Comprehensive MDS Assessment, dated 09/06/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment also indicated the resident was always incontinent for bladder and bowel. Review of Resident #14's Comprehensive Care Plan, dated 09/23/2024, reflected the resident had alteration of bladder and bowel function R/T incontinence and the intervention was use a barrier cream during incontinent care. Review of Resident #14's Physician Order dated 10/11/2021, reflected Apply zinc ointment to buttocks QS and prn. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident #14 on 10/15/2024 at 9:26 AM revealed the resident was in her bed, awake. A container of zinc oxide was observed on top of the resident's left side table. She said the ointment was used every time the staff cleaned her and changed her brief. 4. Review of Resident #35's Face Sheet, dated 10/17/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #35 was diagnosed with irritable bowel syndrome (intestinal disorder that cause diarrhea) and hemorrhoids (swollen veins in the rectum). Review of Resident #35's Comprehensive MDS Assessment, dated 09/24/2024, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment also indicated the resident was always incontinent for bladder and bowel. Review of Resident #35's Comprehensive Care Plan, dated 09/24/2024, reflected the resident had potential/actual impairment to skin integrity and the goal was the resident would be free from injury. Review of Resident #35's Physician Order dated 09/18/2024, reflected May apply barrier cream as needed. Observation and interview with Resident #35 on 10/15/2024 at 10:58 AM revealed a container of zinc oxide was noted on top of the TV stand. The medication was visible from the hallway. Resident #35 said the ointment was used every time she was cleaned. She said it was used to prevent irritation of her buttocks. Observation on 10/16/2024 at 7:35 AM revealed CNA C was providing incontinent care for Resident #35. When CNA C was done cleaning the resident, she took the zinc oxide from the TV stand, took a handful, and applied it to the resident's bottom while the resident was in a side-lying position. After the zinc oxide was applied, she placed the zinc oxide on the resident's overbed table, rolled the resident back, and fixed the brief. CNA C then transferred Resident #35 to her wheelchair and helped the resident with personal hygiene. After providing assistance for Resident #35, CNA C went out of the room. The zinc oxide was left on the overbed table beside the resident's bed. In an interview with CNA C on 10/16/2024 at 11:46 AM, CNA C stated the zinc oxide should not be left on the side table or on the overbed table. she said the resident might be confused and mistakenly swallowed the ointment. She said they might be harmed if the ointment was ingested. CNA went inside Resident #35's room and put the zinc oxide inside the resident's drawer. She then went inside Resident #14's room and also put the resident's zinc oxide inside the resident's drawer. She said she checked the other rooms and made sure the skin protection ointment was inside the drawers and with limited access to other residents and visitors. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 10/17/2024 at 8:24 AM, the DON stated all the medications should be inside the medication carts. She said if a family member was the one bringing the medications, the family member should be educated of the harm if the medications were accessible to others. She said the Miralax, eye drops, and the nasal spray should be inside the cart. She said the zinc oxide, used during incontinent care, should be placed inside the drawer of the side tables after using it. She said the stoma powder should be stored along with the things used for colostomy care inside the drawer of the side table. She said if the resident or a visitor ingested it, there could be adverse reactions especially if somebody who accidentally ingested the medications were allergic to the medications. A child who accidentally swallowed the medication could choke from it. She said the expectation was no medication would be left inside the room and the ointment used for incontinent care be placed inside the drawer to secure it. She said she would do an in-service about medication administration and making sure no medications were left inside the room. In an interview with the ADON on 10/17/2024 at 8:33 AM, the ADON stated medications, whether oral, nasal, eye drops, or topical should be in the medication carts. If those medications were left inside the room, several unsafe outcomes could happen. She said if someone accidently ingested the medication, it could result in nausea, vomiting, or abdominal pain. She said the zinc oxide was used after incontinent care. She said it should be placed inside the drawer or somewhere not accessible after use. She said if a family member was the one bringing the medication and did not want them placed in the medication cart, the medications should be in a plastic bag inside the drawer. She said the expectation was for the staff to make sure there were no medications easily accessible to confused residents and visitors. In an interview with the Administrator on 10/17/2024 at 8:55 AM, the Administrator stated all medications should be in the cart and not inside the residents' room. He said the ointment used for incontinent care should be in the drawer or somewhere secured. He said leaving medications inside the resident's room could result to accidental ingestion. He said the expectation was for the staff to make sure no medications were inside the room or were easily accessible to other residents and visitors. He said he would coordinate with the DON so the issue would not happen again. Record review of facility policy, Medication Labeling and Storage 2001 MED-PASS, Inc. revised February 2023 revealed Policy Statement: The facility stores all medications and biologicals in locked compartments . Medication Storage . 4. Compartments (including . drawers . cabinets . rooms, and boxes) . not left unattended if open or otherwise potentially available to others.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45055 Based on observation, interviews, and record reviews, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen in skilled nursing, reviewed for food storage, labeling, dating, and kitchen sanitation. 1. The facility failed to ensure foods in the refrigerator were properly sealed . 2. The facility failed to ensure the ice machine, located in the kitchen area, was cleaned. 3 The facility failed to ensure the food stored in the refrigerator and freezer were labeled with the stored date. 4. The facility failed to ensure that they had a cleaning/sanitizing bucket (red bucket) under the serving table during lunch service to keep the serving table clean and sanitized. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on 10/15/24 from 9:04 AM to 9:18 AM in the facility's main kitchen in skilled nursing reflected: The ice machine, located in the kitchen area, had rust on the inside door hinges. The inside walls of the ice machine had dark stains and built-up mineral deposits. One large stainless-steel container of reddish sauce, located in the refrigerator, did not have a stored date. One small bowl of cut up melons, located in the refrigerator, did not have a stored date. One zip locked bag of gluten free bagels, located in the refrigerator, did not have a stored date. One 5-pound bag of onion rings, located in the freezer, did not have a stored date. Two large bags of frozen carrots, located in the freezer, did not have a stored date. Two large bags of frozen mixed vegetables, located in the freezer, did not have a stored date. One large box containing a bag of frozen catfish, located in the freezer, was not sealed from air-borne contaminants. Observations on 10/16/24 at 11:15 AM in the facility's main kitchen in skilled nursing reflected: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During lunch service and food being plated, the cleaning/sanitizing bucket (red bucket) under the serving table, was observed to have no cleaning fluids and a dried-up cloth in it. In an interview on 10/17/24 at 12:50 PM, the Dietary Manager was shown pictures of the concerns observed in the kitchen. He stated that the cooks were responsible for ensuring all foods in the refrigerator and freezer were labeled and dated with the stored date. He stated that everyone was responsible for ensuring that the foods are covered and sealed from airborne contaminants. He stated that they clean the ice machine at least once a month. He stated he was aware of the condition of the ice machine door, and they had ordered a new one. He was again shown the rust on the door hinges, and he stated he would have someone clean it. He stated the cooks were responsible for ensuring the red bucket under the serving table, had the appropriate cleaning agent in it, but it was somehow overlooked. He stated the red bucket should have cleaning and sanitizing agent in it to assist in cleaning the serving table clean. He stated the concerns observed in the kitchen could result in food contamination. In an interview on 10/17/24 at 01:15 PM, the Administrator was shown the pictures of the concerns observed in the kitchen. He stated he expected his kitchen to ensure that they complied with guidelines. He stated he was aware there was an issue with the condition of the ice machine door, and one was being ordered. He was advised that there was rust observed on the hinges, which could be cleaned or needed to be replaced. He stated the concerns observed in the kitchen could result in food contamination. Record review of the facility's policy Food and Nutrition Services (October 2017) revealed Food shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). Record review of the facility's policy Kitchen Sanitization (November 20222) revealed The food service area is maintained in a clean and sanitary manner. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD

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NAME OF PROVIDER OR SUPPLIER: Rambling Oaks Courtyard Extensive Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 112 Barnett Blvd Highland Village, TX 75077	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #24 and Resident #35) of eight residents reviewed for Infection Control. 1. The facility failed to ensure that LVN A changed her gloves and performed hand hygiene while administering ointment to Resident #24's nose. 2. The facility failed to ensure that CNA C changed her gloves and performed hand hygiene while providing incontinent care to Resident #35. 3. The facility failed to ensure that LVN A performed hand hygiene while administering wound care to Resident #35. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #24's Face Sheet, dated 10/16/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #24 was diagnosed with unspecified pain. Review of Resident #24's Comprehensive MDS Assessment, dated 10/04/2024, reflected the resident was cognitively intact with a BIMS score of 15. Resident #24's Quarterly MDS Assessment indicated the resident had unspecified pain. Review of Resident #24's Comprehensive Care Plan, dated 09/09/2024, reflected the resident would be free from infection and one of the interventions was administer antibiotics as per order. Review of Resident #24's Physician Order, dated 10/10/2024, reflected Mupirocin External Ointment 2 % (Mupirocin). Apply to both nostrils topically (applied to the surface of the skin) three times a day for infection for 7 days apply inside both nostrils (openings of the nose) and on lesion below the right nostril. Observation and interview on 10/16/2024 at 8:00 AM revealed LVN A was administering Resident #24's medication. One of the medications was an ointment for the nose. LVN A prepared the ointment and the cotton tip applicator. Before LVN A applied the ointment, she sanitized her hands and put on a pair of gloves. After putting on the gloves, LVN A pulled the trash can near her using the same gloves. After pulling the trash can, LVN A proceeded to apply the ointment to the nose using the same gloves. She did not change her gloves or perform hand hygiene after touching the trash can. LVN A stated she should have changed her gloves after touching the trash can because the trash can was dirty. She said her action could cause cross contamination and infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #35's Face Sheet, dated 10/17/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #35 was diagnosed with kidney disease and cystitis (inflammation of the urinary bladder). Review of Resident #35's Comprehensive MDS Assessment, dated 09/24/2024, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment also indicated the resident was always incontinent for bladder and bowel. Review of Resident #35's Comprehensive Care Plan, dated 09/24/2024, reflected the resident had an ADL self-care performance deficit and would require one to two staff participation during toilet use. Another Care Plan, dated 09/24/2024, reflected the resident had potential/actual impairment to skin integrity and the interventions were avoid scratching and use lotion on dry skin. Review of Resident #35's Progress Notes, dated 10/16/2024, reflected during care res (resident) obtained skin tear 1cm x1cm on left leg, cleaned site with ns and applied dry dressing. Observation and interview on 10/16/2024 at 7:35 AM revealed CNA A was about to do Resident #35's incontinent care. CNA C washed her hands, put on a pair of gloves, and lowered the head of the bed. CNA C then pulled the resident's overbed table and put everything she needed for incontinent care. CNA C also reached for the waste can and put in beside her. She removed her gloves and put on a new of gloves. She did not sanitize her hands. She unfastened the brief and pushed it between the resident's legs. She cleaned the resident's front part from back to front. She assisted the resident to roll to the right side and started to clean the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief, and threw it in the trash can. She then took the new brief that she put in the overbed table and placed it under the resident. She did not change her gloves before touching the new brief. She removed her gloves and went to the bathroom to get some more gloves. She put on a new pair of gloves and put some ointment on the resident bottom. She did not sanitize her hands. She removed her gloves and put on a new pair of gloves after the ointment was applied. She did not sanitize her hands. CNA C assisted the resident to roll back and fixed the brief. CNA C then put on the resident's pants and transferred the resident to her wheelchair. CNA C stated she should have changed her gloves when she took the new brief because her gloves were already soiled. She said she forgot to sanitize her hands when she changed her gloves. She said not changing her gloves and not sanitizing in between could result to cross contamination and infection. Observation and interview on 10/16/2024 at 7:55 AM revealed LVN A was called by CNA C because Resident had a skin tear to her left leg. LVN A came inside the room with materials for wound care in a plastic bag. LVN A washed her hands and put on a pair of gloves. LVN A assessed the wound and said it was a skin tear with no flap and was measuring around one cm by one cm. Scant bleeding was observed. LVN A cleaned the wound with normal saline and patted it dry. After patting the skin tear dry, LVN A took a dry dressing and covered the wound. She did not sanitize her hands when she changed her gloves. She stated she was in a hurry that was why she forgot to sanitize her hands when she changed her gloves. She said sanitizing hands in between changing of gloves was done to prevent cross contamination and infection. In an interview with Resident #35 on 10/16/2024 at 11:49 AM, Resident #35 said she was scratching her leg earlier and might be the cause of the skin tear. She said her legs were so dry that was why the aides were putting lotion on it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 10/17/2024 at 8:24 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and infection. She said gloves should be changed after touching the soiled brief and after touching the trash to prevent transfer of microorganisms to any clean items. She said the staff should do hand hygiene before putting on a new pair of gloves during wound care and incontinent care. She said the expectation was for the staff to change their gloves when going from dirty to clean and to do hand hygiene when changing the gloves. She said she would do an in-service and skills check-off for infection control and would observe the staff personally. She said the goal was to provide quality and professional care to the residents. In an interview with the ADON on 10/17/2024 at 8:33 AM, the ADON stated hand hygiene was included in all the procedures of any care. She said the staff should do hand hygiene before care was done, after any care, and in between changing of gloves. She said gloves should be changed after cleaning the residents' bottoms, after touching the trash can, before getting a new brief. She said not changing the gloves after touching soiled items, or after touching soiled body parts could result in cross contamination and probable infections. She said the expectation was for the staff to do hand hygiene before and after every care, after changing their gloves, and when transitioning from a dirty site to a clean site. The ADON said she would collaborate with the DON regarding in-services about infection control and hand hygiene. In an interview with the Administrator on 10/17/2024 at 8:55 AM, the Administrator stated staff should make sure to change their gloves after touching anything soiled and sanitize their hands before putting on new gloves. He said not changing the gloves after touching soiled items, and not sanitizing the hands, could contribute to cross contamination and infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said he would collaborate with the DON to in-service the staff about infection control. Review of facility policy, Handwashing/Hand Hygiene 2001 MED-PASS, Inc. revised October 2023 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections . Indications for Hand Hygiene . c. after contact with blood, body fluids, or contaminated surfaces . f. before moving from work on a soiled body site to a clean body site on the same resident . g. immediately after glove removal. Review of facility policy, Perineal Care 2001 MED-PASS, Inc. revised February 2018 revealed Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation . Steps . 2. Wash and dry your hands thoroughly . 7. Put on gloves . b. Wash perineal area . c. Wash hand, or use hand sanitizer . 10. Remove gloves . 16. Wash and dry your hands thoroughly.