STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview and record review the facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 1 of 6 residents (Resident #1) reviewed for a clean and comfortable environment. The facility staff failed to remove a soiled brief from the floor in Resident #1's room. This failure could place residents at risk of living in an unsanitary environment leading to a diminished quality of life. Findings include: Record review of Resident #1's Admission Record, dated 10/11/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included nontraumatic intracerebral hemorrhage in hemisphere (bleeding in the brain not caused by trauma); hydrocephalus (build-up of fluid in the brain); asthma; aphasia (disorder that causes inability to communicate); and gastrostomy (surgical opening in the stomach to allow feeding through a tube). Record review of Resident #1's electronic medical record reflected his initial MDS assessment was still in progress and was not completed. Record review of Resident #1's Functional Performance Observation, dated 10/08/24, reflected he was dependent on staff for all his ADLs which included oral hygiene, toileting, bathing, dressing and personal hygiene. Record review of Resident #1's Care Plan reflected the following entries: ADL Self Care Performance Deficit r/t CVA [stroke causing damage to the brain]. Date initiated 10/07/24. Goal: Staff will provide the level of physical assistance with ADLs as needed D/T Resident's self-ability may fluctuate throughout the day. Will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/10/24 at 11:00 AM, Resident #1 was observed in his room. He was sleeping in a specialized wheelchair. His right hand and forearm were observed to be in a splint. A pole was behind his chair with a container of tube feeding attached. There was an odor of urine in the room. A soiled brief was observed on the floor between the wheels of Resident #1's bed and his tube feeding pole. The soiled brief had been rolled up and the inside was not exposed. There were two small white pieces of paper near the brief. During an interview and observation on 10/10/24 at 11:26 AM, CNA A stated she last provided incontinent care to Resident #1 about an hour and a half earlier and he was due to be transferred back to bed and changed soon. She stated Resident #1 had not been at the facility very long, he was nonverbal and required a mechanical lift for transfers. The urine odor was still present in the room . The soiled brief was in the same area on the floor. CNA A returned with NA B, incontinent supplies and a mechanical lift. Both staff transferred Resident #1 to his bed using the lift. The brief he was wearing was placed in a bag along with the soiled wipes and tied up upon completion. He was positioned for comfort onto his left side. Both staff washed their hands and removed the bagged trash and mechanical lift from the room. The soiled brief remained on the floor after the staff left the room. An observation and interview on 10/10/24 at 12:53 PM revealed Resident #1 was sitting up in bed and was awake. He had a visitor in the room who identified himself as a friend and stated he was unaware of any concerns. The soiled brief was no longer on the floor, but pieces of paper remained. No odors were observed in the room. During an interview on 10/10/24 at 2:09 PM, LVN C identified herself as Resident #1's Charge Nurse. She stated she made regular rounds in resident rooms in the morning and during the day as did the CNAs. She stated she had not received any complaints from the residents about the conditions of their rooms. LVN C stated she was not aware there was a soiled brief on the floor in Resident #1's room and she thought it was possibly dropped during morning care. LVN C stated trash should be removed from the room after each incontinent care was provided. She stated the risks included infection control issues and causing the residents and families to be upset. She stated the residents had a right to a clean room. In an interview on 10/11/24 at 8:30 AM, the DON stated finding a soiled brief on the floor in a resident's room was not acceptable. She stated the rooms should be checked every time staff were in the room. She stated the risks of leaving soiled briefs on the floor included infection control issues, odors and no resident would want that. During an interview with Housekeeping Staff D on 10/11/24 at 10:11 AM, she stated the floors in the resident's rooms were swept and mopped every day and as needed. She stated the staff could let them know any time if additional cleaning was needed. She stated the floors in the resident rooms were to be checked every time they were in the room, but it was sometimes difficult to mop the whole floor depending on the resident's position or other equipment in the room at the time they cleaned it. Housekeeping Staff D stated, if they were unable to access an area of the floor, they should check back later in the day. She did not recall seeing a soiled brief in any room the previous day. Housekeeping Staff D stated keeping the residents' rooms clean was important to prevent infections and odors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/11/24 at 11:59 AM, CNA E stated she worked on Resident #1's hall and floated to other halls as needed. She stated soiled briefs and wipes should be bagged and removed from a resident's room every time they were changed. She stated the risk for leaving the soiled items in the room included infection control and foul smells that could upset the resident. In an interview on 10/11/24 at 12:15 PM, RN F stated she conducted room rounds on her hall throughout her shift which included checking the residents' conditions as well as ensuring the room was in order. She stated it was never appropriate to leave soiled briefs in a residents' room after incontinent care was performed. She stated the items should have been bagged at the time care was provided and removed from the room after completion. RN F stated soiled linen should be removed at that time as well. She stated the risks of leaving soiled items in the room included infection control issues and embarrassment to the resident due to odors. In an interview on 10/11/24 at 12:55 PM, the DON stated the Housekeeping Supervisor was responsible for ensuring the resident rooms were clean. She stated the administrative staff performed Angel Rounds in all the resident's rooms every day. She stated the rounds ensured they checked on all the residents and addressed any concerns they had. They also assessed the conditions of the rooms and shared any information they received, such as complaints or maintenance issues, during their morning meetings. The DON stated, a soiled brief left on the floor was the responsibility of the nursing staff. She stated she did not know how it occurred unless they were using a trash can and missed. During an interview with CNA A on 10/11/24 at 1:08 PM, she stated she saw the soiled brief on the floor in Resident #1's room a little later after providing care for him and observed the day before. She stated she removed the brief and had no idea how it got there. CNA A stated she provided care for him earlier that morning and thought she possibly overlooked it as it was partially under the bed and his wheelchair was nearby. She stated the risk of having a soiled brief on the floor was it was not sanitary and could spread infection. She stated it could upset a resident having something like that on their floor and could cause odors in the room. In an interview on 10/11/24 at 1:18 PM, the MDS Nurse stated she conducted Angel Rounds in Resident #1's room on 10/10/24. She stated, during the rounds, she typically checked on the residents to address any concerns, checked the general condition of the rooms and bathrooms for cleanliness and maintenance issues, and ensured their call light and other necessary items were within reach. The MDS Nurse stated she did not recall noting any odors in the room or seeing a soiled brief on the floor. She stated, if she had, she would have removed the item and discussed it with the nursing staff. She stated the risks included a tripping hazard for some residents, infection control and a violation of a resident's right to have a clean room. During an interview with the Housekeeping Supervisor on 10/11/24 at 1:40 PM, she stated the housekeeping staff conducted rounds on every resident room daily. She stated the rounds including ensuring hand sanitizer and soap was available, refilling paper towels, cleaning the bathrooms, air vents and sweeping and mopping the floors every day. She stated the floors should be completely cleaned which included moving furniture when necessary. The Housekeeping Supervisor stated a soiled brief found on the floor would certainly be removed if found but was the responsibility of the nursing staff to prevent. She stated the risk included infection control, creating a tripping hazard, causing odors in the room, and violating the resident's rights if their rooms were not kept clean for them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled; Safe Comfortable Homelike Environment, dated Revised/Reviewed 1/2022, reflected the following: Policy: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible . 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order