STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr Houston, TX 77070

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review, the facility failed to provide dignity and respect for 1 of 6 (Resident #20) residents observed for dignity in that: -The facility failed to close the blinds to Resident # 20's window during Foley catheter care. This failure could place residents who require assistance with care at risk for embarrassment and lower self-esteem. Findings include: Record review of Resident #20's face sheet dated 08/29/2024 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #20's diagnoses included the following: dementia (memory loss), retention of urine (unable to empty the bladder completely), acute (suddenly) kidney failure, hydronephrosis (build up of fluid in a kidney due to a backup in urine), benign (non-cancerous) prostatic hyperplasia (prostate enlargement) and, diabetes mellitus (too much sugar in the blood). Record review of Resident #20's MDS (5-day scheduled Assessment) dated 07/09/2024 reflected a BIMS score of 9 indicating resident cognition was moderately impaired. Section H (Bladder and Bowel) reflected that resident was frequently incontinent of urine. Record review of Resident #20's Physician Order Summary Report reflected the following order: - Dated 07/18/2024 catheter type: 16 Fr #10 ML to closed urinary drainage system-diagnosis for BPH. Record review of Resident #20's care plan dated 08/29/24 reflected that resident had an indwelling catheter due to BPH with an intervention that included: provide catheter care every shift and as needed. Further review reflected that resident was being care planned for ADL self-care performance r/t impaired mobility with an intervention to promote dignity by ensuring privacy. Observation on 08/28/24 at 10:20AM revealed Resident #20 was resting in bed B by the window. Resident had an indwelling Foley catheter bag draining to gravity on the right side of bed. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/29/24 at 1:35PM of Foley catheter care for Resident #20 by CNA X and CNA Y. Resident window blinds were open. CNA X and CNA Y proceeded with care by pulling resident covers back to clean resident groin (area between the stomach and thigh on both sides of the body) and urinary meatus (opening where urine exits) without closing the blinds on the window. Interview on 08/29/24 at 1:40PM with CNA Y, she said she gave herself on a scale from 1-10 a 7.5 because she should have closed resident blinds on window for privacy to promote dignity. Interview on 08/29/24 at 2:00PM with the DON, she said whenever staff provided care for the resident (s), privacy should be provided to promote dignity. Record review of the facility policy on Dignity revised October 2009 reflected in part: . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview and record review, the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 of 6 residents (Resident # 20) reviewed for pressure sores in that: - The facility failed to off load Resident #20's heels by floating them on a pillow or by placing heel protectors on resident heels to prevent further skin breakdown. This failure affected one resident and placed him at risk of developing further skin breakdown or developing of new pressure injury. Findings include: Record review of Resident #20's face sheet dated 08/29/2024 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #20's diagnoses included the following: dementia (memory loss), retention of urine (unable to empty the bladder completely), acute (suddenly) kidney failure, hydronephrosis (buildup of fluid in a kidney due to a backup urine), benign (non-cancerous) prostatic hyperplasia (prostate enlargement) and, diabetes mellitus (too much sugar in the blood). Record review of Resident #20's MDS (5-day scheduled Assessment) dated 07/09/2024 reflected a BIMS score of 9 indicating resident cognition was moderately impaired. Section GG (Functional Abilities) of the MDS reflected that resident required maximal assistance. Section M of the MDS reflected that resident did not have any ulcers, wounds and skin problems. Record review of Resident #20's care plan dated 07/01/2024 revised 07/15/2024 reflected that resident was being care planned for potential for pressure ulcer development r/t impaired mobility with intervention for weekly head to toe skin assessments. Further review reflected resident being care planned for a pressure ulcer to right heel dated 08/27/2024. The interventions included the following: -Administer treatments as ordered and monitor for effectiveness. -Encourage to turn reposition, provide assistance as necessary. -Float heels as tolerated. Record review of Resident #20's Physician Order Summary Report reflected the following orders: -Dated 08/26/2024 right heel: apply betadine and leave heel open every day for wound healing (discontinue 08/29/2024) -Dated 08/29/2024 Right heel: Apply skin prep and leave heel open to healing Record review of Resident #20's TAR dated 08/2024 revealed that the facility was following physician orders for wound to the right heel in applying medication to right heel. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #20's weekly skin assessment dated [DATE] reflected right heel pressure wound measuring 6cm x7.5 cm width x 0 cm in depth unstageable. Observation on 08/29/24 at 1:35PM revealed Resident #20 was in bed with the staff CNA X and CNA Y preparing to provide Foley catheter care for resident. Resident #20's heels were not off loaded off the bed nor was the resident wearing any heel protectors. Resident #20 was observed having skin breakdown to his right heel with skin discoloration. The right heel had a black large circle with no drainage observed. When the staff was done with providing care for Resident #20, they repositioned the resident in bed on his back without offloading the resident's heels. Interview with CNA Y on 08/29/2024 at 1: 45PM, she said she was Resident #20's CNA. CNA Y said Resident #20's heels should have been offloaded to prevent skin breakdown. CNA Y began to look in the resident's drawers in the room. CNA Y found heel protectors in one of the resident's drawers. Interview on 08/29/24 at 1:50PM with RN Z, she said it was the nurse's responsibility as well as the CNA's to ensure resident's heels were being offloaded to prevent pressure injury. Interview on 08/29/2024 at 2:00PM the DON said heel protectors should be used or the staff should be offloading the residents' heels to prevent pressure injury. Record review of the facility policy on Quality of Care (Skin and Wound Monitoring and Management) revised 12/ 2023 reflected in part . A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and . a resident having pressure injury (s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing .Unstageable pressure injury: Obscured full- thickness skin loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dry black hard necrotic{dead tissue} tissue). If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed .

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #10) of two residents reviewed for incontinence care. -The facility failed to ensure CNA W provided appropriate perineal care for Resident #10 after an incontinent episode when she failed to open the labia to clean and wipe around resident's buttocks. This failure could place residents at risk for the development and/or worsening of urinary tract infections and skin breakdown. Findings include: Record review of Resident #10 's annual MDS assessment, dated 07/15/24, reflected a [AGE] year-old female with an admitted [DATE]. Her diagnoses included urinary tract infection, cerebrovascular disease (stroke, brain aneurysms and cerebral arteriovenous/blood clots), muscle wasting and atrophy, stage 4, type 2 ,diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly, causing blood sugar levels to rise) without complications, morbid obesity due to excess calories. Resident #10 had a BIMS score of 12, which indicated she had moderately impaired cognition. She required extensive assistance of -two-persons with all ADLs and was always incontinent of bowel and bladder. Record review of Resident #10 's care plan, dated 3/31/24, reflected, . The resident has an ADL self-care deficit .Interventions .Personal hygiene and Toilet use- Resident is totally dependent An observation on 08/28/24 at 10:35 a.m. revealed CN.A W entered Resident #10's room preparing to provide incontinence care. CNA W put on clean gloves and unfastened Resident #10's brief soiled with urine . CNA W took a peri-wipe and cleaned residents' perineal area; she did not open the labia to wipe. CNA W assisted the resident to roll on her right side. CNA W took a peri-wipe and wiped in-between residents' rectal area and did not wipe around the buttocks. Review of CNA W's skill checks dated 07/30/24 reflected she was competent in performing peri-care . Interview with CNA W on 08/29/24 at 10:15 a.m. she stated she was supposed to open the labia to clean and around the buttocks. She stated she knew the importance of properly cleaning a resident and by not doing so, placed them at risk of infections. Interview with the DON on 08/29/24 at 02:00 p.m., she stated staff were to open labia and clean around residents' buttocks. She stated by not following proper peri care it placed residents at risk of urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Perineal care, revised March 2017, reflected, .Wash and dry hands thoroughly .put on gloves .wash perineal are , wiping from front to back .Separate labia and wash area downward from front to back . Assist the resident to turn on her side .Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks .Rinse and dry thoroughly 35822

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 of 2 residents (Resident #32) reviewed for oxygen in that: -Resident #32's oxygen humidifier was not labelled with the date it was changed. This deficient practice could affect residents who received oxygen continuously and could result in residents receiving incorrect or inadequate oxygen support. Findings include: Record review of Resident #32's face sheet revealed, Resident #32 is a [AGE] year-old who was originally admitted to the facility on [DATE]. Their medical diagnoses included: type 2 diabetes mellitus, chronic obstructive pulmonary disease, dysphagia (difficulty swallowing), cognitive communication deficit, hyperlipidemia (high fat in blood), dementia, hypertension (high blood pressure), and chronic kidney disease (kidney not functioning normally). Record review of Resident #32's care plan last updated 05/04/2024 revealed: -Resident #32 has Oxygen Therapy. Interventions included: give medications as ordered by physician. Monitor/document side effects and effectiveness, and monitor for symptoms of respiratory distress and report to the doctor as needed. Record review of Resident #32's Physician's orders last updated 08/24/24 revealed they had the following orders: -Oxygen at 3L/min continuous per every shift -Change o2 tubing & humidifier bottle Record review of Resident #32's August MAR, reflected the resident had an order for oxygen tubing and humidifier bottle change every night shift on Wednesdays with an order date of 06/12/2024. It was last changed on 08/28/2024. Observation and interview with Resident #32 on 8/29/24 at 4:35pm, she said she was doing fine and there were no issues with her oxygen equipment. She said nurses come to check on her often. Resident #32's humidifier did not have a date written on it. Interview with LVN A on 8/29/2024 at 4:40pm, she said Resident #32 tends to change the humidifier on her own and her family brings in home supplies for her to use but that LVN A should have checked on the humidifier that morning to make sure it was labelled correctly. LVN A said she will immediately go and label it and it should have been done and checked every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Oxygen Equipment policy and procedures last revised May 2007, reflected it stated it is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner . this equipment is to be discarded after use .Pre-filled humidifiers, when used, are to be dated and replaced every ten (10) days, according to manufacturer recommendation, or as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 16352 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 1 medication rooms (Medication Room) and 2 (Halls 300 and 400 medication carts) of 4 medication carts reviewed for medication storage. - The facility failed to ensure the Medication Room did not contain multidose PPD (Tuberculin Purified Protein Derivative Diluted Aplisol) containers with no patient identifiers without opened date on container. - The facility failed to ensure the 300 and 400 hall medication carts did not contain eyedrops and nasal spray that were opened but not labeled with the resident's name and not dated. This failure could place residents at risk of adverse medication reactions and infections. Findings Include: During observation on 08/29/24 at 12:25 PM, the following medications were found in the medication carts for 300 and 400 hall with MA A: 300 Medication Cart 1.Dorzol/Timolol solution 2.0-.5% ophthalmic open not dated and no name 2. Latanoprost Solution 0.005% open not dated and no name 400 medication cart: 1. Fluticasone Propionate Nasal Spray 50mcg 3 spray bottles open and not dated 2. Artificial Tear lubricant eye drop open not dated 3. Refresh Optive eye gel Extended relief open not dated and no name 4. Systane lubricant eye Gel drops lubricant eye gel open not dated and no name 5. Dorzol/Timolol solution 2.0-.5% ophthalmic open not dated and no name 6. Dorzol/Timolol solution 2.0-.5% ophthalmic open not dated and no name 7. Latanoprost Solution 0.005% open not dated and no name (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MA A on 8/29/24 at 12:54 PM, she said whenever any eye drops and nasal spray were opened, it should be dated with resident name, to help determine when to discard it. During observation on 08/29/24 at 1:25 PM, the following medications were found in the medication room refrigerator with DON: 2 vials of Tuberculin Purified Protein Derivative derivation Diluted Aplisol (PPD) 5TU/0.1ml open not dated. Interview with DON at 1:30 PM, she said the eye drops and PPD while open should be dated and it was to make sure the effectiveness. DON said that all medications must have pharmacy labels, which include open date of medication. She said the observed eye drops were not appropriately labeled because they had no patient identifiers and not consistent with their facility labeling practices. The DON said since the medications lacked patient name they could no longer be used and must be discarded in the drug disposal bin located in the medication room. She said the use of multidose PPD containers with no open date could place residents at risk of medication errors. Record review of the facility policy titled Medication Labels revised 11/13/18 revealed, a- each prescription label includes: 1- resident's name, 2- specific directions for use, including route of administration. B- improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy. G- medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacy for relabeling or destroyed in accordance with the medication destruction .

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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** 16352 Based on observation, interview, and record review, the facility did not maintain an infection prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 Staff (CNA W) reviewed for infection control. - The facility failed to ensure CNA W followed proper hand hygiene during incontinent . - The Wound Care Nurse did not practice hand hygiene before and after wound care for Resident #20. These deficient practices could affect residents and place them at risk for infection, and reinfection. Findings include: Record review of Resident # 10's annual MDS assessment, dated 07/15/24, reflected a [AGE] year-old female with an admitted [DATE]. Her diagnoses included urinary tract infection, cerebrovascular disease (stroke, brain aneurysms and cerebral arteriovenous/blood clots), muscle wasting and atrophy, stage 4, type 2 diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly, causing blood sugar levels to rise) without complications, morbid obesity due to excess calories. Record review of Resident #10's annual MDS assessment dated [DATE] revealed she had a BIMS score of 11/15 (moderately cognitively impaired). She required extensive assistance of two-persons with all ADLs and was always incontinent of bowel and bladder. Record review of Resident #44's care plan, dated 3/31/24, reflected, . The resident has an ADL self-care deficit .Interventions .Personal hygiene and Toilet use- Resident is totally dependent An observation on 08/28/24 at 10:35 a.m. revealed CNA BB entered Resident #10's room preparing to provide incontinence care. CNA W washed her hands and put on cleaned gloves did not change gloves, using the same gloved hands , picked up the clean wipes from the container on the bedside table and unfastened Resident #10 's brief soiled with urine. CNA W assisted the resident to roll on her right side. CNA W took a peri-wipe and wiped in-between residents' rectal area . With the same gloves, CNA W applied barrier cream to a chafed area on the resident buttocks and then removed the soiled brief and placed a clean brief under the resident and assisted her to roll back onto her back and fastened the brief. CNA W removed her gloves and did not wash her hands. She picked up a clean blanket from Resident #10 's drawer and place it, on Resident #10. Review of CNA W's skill checks dated 07/30/24 reflected she was competent in performing peri-care and hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA W on 08/29/24 at 10:15 a.m. she stated she was supposed to wash her hands before and after performing incontinent care and change her gloves when she finished. She stated she knew the importance of properly cleaning a resident and by not doing so, placed them at risk of infections. Interview with DON on 08/29/24 at 02:00 p.m., the DON said CNA W's should wash or sanitize her hands when soiled and after changing gloves. DON said CNA W would be retrained before working with incontinent residents. Resident #20 Record review of Resident #20's face sheet dated 08/29/2024 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #20's diagnoses included the following: dementia (memory loss), retention of urine (unable to empty the bladder completely), acute (suddenly) kidney failure, hydronephrosis (buildup of fluid in a kidney due to a backup urine), benign (non-cancerous) prostatic hyperplasia (prostate enlargement) and, diabetes mellitus (too much sugar in the blood). Observation on 08/29/2024 at 3:22PM of wound care nurse entering Resident #20's room to assess the resident's heels. The wound care nurse did not wash or sanitize her hands before applying gloves to assess the resident's heels. After assessing the resident's heels, the wound care nurse removed her gloves and balled the gloves up in her hand before leaving the resident room without washing or sanitizing her hands. Interview on 08/30/24 at 1:37PM with the wound care nurse, she said she had forgotten to wash her hands prior to and after assessing Resident #20's heels on 08/29/2024. The wound care nurse said hand washing was important to prevent infections. Record review of the facility's policy titled Handwashing/Hand Hygiene (revised May of 2007) revealed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; Or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections. Record review of the facility's policy titled, Perineal care, revised March 2017, reflected, .Wash and dry hands thoroughly .put on gloves .wash perineal area, wiping from front to back .Separate labia and wash area downward from front to back . Assist the resident to turn on her side .Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks .Rinse and dry thoroughly