

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Mememorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 Blalock Houston, TX 77055	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669</p> <p>Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 5 (Residents #21 #22, #44, #51 and #108) of 16 residents reviewed for cleanliness and sanitization.</p> <ol style="list-style-type: none"> 1. The facility failed to address damaged and unclean walls in Residents #22, #44, and 51's room. 2. Resident #21's headboard was loose and moving back and forth. 3. Resident #108's wash basin on the nightstand that was not labeled and there was another wash pan in the bathroom that was not labeled or bagged. <p>These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.</p> <p>The findings include:</p> <p>Observation on 2/11/2025 at 9:41am in Resident #51's room revealed the wall at the head of bed had missing paint.</p> <p>Observation on 2/11/2025 at 10:07am in Resident #44's room revealed the room had a hole in the wall with a TV plug hanging out. The wall facing the resident's bed also had several areas of chipped wall paint and appeared dirty. Later interview with Resident #44 on 2/11/2025 at 2:27pm, she said she wanted to go back to her old room because the room she was currently in was [NAME], and she pointed at the markings and holes in the wall in front of her bed.</p> <p>Observation on 2/11/2025 at 1:59pm of Resident #22's room revealed paint chipped off along all of the baseboard by his bed. Resident #22 was not interviewable.</p> <p>Observation on 02/11/25 at 2:27PM of Resident #21's headboard revealed it was not attached securely to the bed (moving back and forward). The wall on the left side of the bed had brown stains. There was a hole in the wall on the right side of bed near the head of bed with wiring exposed.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 02/11/25 at 2:30PM with the DON after she observed the Resident #21's and #22's rooms said she would have to call maintenance to make the necessary repairs in the resident room. The DON said any environmental issues in the facility, the staff were supposed to communicate with the maintenance department in the computer system. The DON said it was the responsibility of the staff (CNAs, nurses, unit managers, and the ambassadors) to make rounds on the resident rooms and when they saw any abnormalities, they were to report to maintenance or housekeeping to go and resolve the problem. The DON said housekeeping was notified verbally.</p> <p>Interview on 02/11/24 at 2:40PM ADON K said she was the Unit Manager for the hall where Resident #21 resided. ADON K said she was not aware of Resident #21's room having a hole in the wall with wires exposed or the resident's wall not being clean. ADON K said she was also not aware of the resident's headboard being broken. ADON K said it was very important to keep the resident rooms and their environment presentable because it was their home. ADON K said if that was not done, it could place the resident at risk for infections and not feeling good about their environment. ADON K said because residents had visitors, it was important to make the resident space presentable. ADON K said she would take care of the matter right away.</p> <p>Interview on 02/11/25 at 2:48PM with the Housekeeping Supervisor said the residents' rooms were to be cleaned daily and as needed. When the Housekeeping supervisor observed the walls in Resident #21's room, he said the wall needed to be cleaned. The Housekeeping supervisor said when Housekeeping cleaned the resident room, they were supposed to pay attention to the resident walls to see if it needed to be cleaned for infection control. The supervisor said the Housekeeper for Resident #21's room had gone home for the day.</p> <p>Interview on 02/11/25 at 3:00PM CNA T said she was the CNA for Resident #21. CNA T said a CNA who name she could not remember said she had reported to the maintenance department about Resident #21's headboard being broken approximately a week ago, but nothing had been done about it. CNA T said she was aware of the walls in the resident's room being dirty and informed Housekeeper U about it. CNA T said Resident #21's walls had been dirty for a while. CNA T said it was important to keep the residents' rooms clean for appearance. CNA T said if the resident room was not cleaned and maintained properly, it placed the resident at risk for infections or mold. CNA T said a broken headboard could place the resident a risk for injuries.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview 02/11/25 at 3:16PM with the Maintenance Director said he had been working at the NF approximately five to six months. The Maintenance Director said he was responsible for work orders communicated to him in the computer system regarding the environment of the facility. The Director said he checked work orders daily and was not aware of Resident #21's room having a hole in his wall with visible wiring inside of it or the resident's headboard being broken until the present time. The Director said the issues were being taken care of at present time. The Director said the hole in resident's room wall was a communication line and should be covered. The Director said the ambassadors were supposed to communicate with him if they saw any environmental issues in the residents' rooms. The Director said the ambassadors were supposed to make daily rounds in the resident rooms. The Director said with the open hole in Resident #21's wall and broken headboard put the resident in danger. Further interview, the Director said after speaking with the Regional Maintenance Director , the loose headboard placed the resident at risk of falling if not repaired. The Director said the hole in the wall put the resident at risk of allowing pests to enter in the room. He said that he receives work orders through the computer which he checked daily, which included pests and room maintenance such as holes in the wall and open wiring. He said some staff are referred to as ambassadors and they are to make rounds each morning and throughout the day and are to report any environmental issues they observed. He said that he did not have any concerns regarding pests recently but saw a concern in the system today related to a spider earlier in the day. The Maintenance Director said he went into that particular room but did not find anyone else but he called pest control who will come on 2/12/2025.</p> <p>Interview on 02/13/25 at 8:40AM with the DON and the Regional Nurse after reviewing the Ambassador Round Assignment reflected that the Maintenance Director was Resident #21's ambassador.</p> <p>Resident #108</p> <p>Record review of Resident #108's face sheet dated 02/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included: cerebral infarction (blood flow to the brain is interrupted), muscle atrophy (a condition that causes muscle tissue to thin or waste away), and aphasia (disorder that affects a person ability to communicate effectively).</p> <p>Record review of Resident #108's admission MDS dated [DATE] reflected a BIMS score of 3 indicating the resident's cognition was severely impaired.</p> <p>Observation on 02/11/25 at 9:11AM of Resident #108's room revealed there was of a gray wash basin sitting on top of nightstand by Resident #108's bed on the left side. The wash basin was not labeled or inside of a bag. Further observation was made of a wheelchair leg rest sitting on top of the gray wash basin. Observation was made of another gray wash basin inside of the bathroom sitting on top of a rolling walker that was not dated or inside of a bag. Further observation of Resident #108's room revealed she was not in the room.</p> <p>Observation on 02/11/25 at 1:55PM in Resident #108's room revealed there was a gray wash basin in same areas of the room with no label and was not bagged.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident needing respiratory care, including tracheostomy care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 6 of 8 (Residents #14, #21, #11, #17, #43 and #86) reviewed for oxygen.</p> <p>Resident #14's continuous oxygen was observed set at 8L/min on 02/11/2025 when he had a physician order for continuous oxygen at 6L/min.</p> <p>Resident #21's nebulizer machine was on the floor on the left side of his bed. The resident had respiratory tubing that was attached to a mask hanging on wheelchair at the bedside.</p> <p>Resident #11's nebulizer tubing and mask was not dated and placed inside of plastic bag when not in use.</p> <p>Resident #17's oxygen tubing was lying on the floor and nebulizer tubing and mask was not dated and placed inside of plastic bag when not in use.</p> <p>Resident #43's and #86's oxygen (O2) tubing was not stored off the floor in a clean and sanitary location.</p> <p>The failures placed residents at risk for respiratory infections and inadequate respiratory care.</p> <p>Findings Included:</p> <p>Resident #14</p> <p>Record review of Resident #14's face sheet last captured 02/13/2025 revealed a [AGE] year-old male originally admitted on [DATE]. His medical diagnoses included anoxic brain damage (brain damage from lack of oxygen), muscle wasting and atrophy, cognitive communication deficit, tracheostomy status, chronic congestive heart failure, and pneumonia (infection of the lungs).</p> <p>Record review of Resident #14's Comprehensive MDS dated [DATE] revealed that he was receiving oxygen therapy at the facility.</p> <p>Record review of Resident #14's baseline care plan dated 02/09/2025 revealed he was receiving oxygen therapy, with interventions including monitoring for s/sx of respiratory distress and report to MD PRN.</p> <p>Record review of Resident #14's Physician's Orders last updated 02/11/2025 at 3:36pm revealed he had an order with a start date of 02/08/2025 for Oxygen at 6LPM (liters per minute) via trach every shift for hypoxia.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #14's care plan last updated 02/10/2025 revealed he was had a focus area of having oxygen therapy r/t ARF and trach (tracheostomy, a surgical procedure that creates an opening in the windpipe to provide an airway for breathing) placement with a last revised date of 02/11/2025. Interventions included O2 via as ordered and position resident to facilitate ventilation.</p> <p>Record review of Resident #14's BIMS (a short assessment to determine a person's cognitive intactness) assessment dated [DATE] revealed a score of 0, indicating Resident #14 had severe cognitive impairment. He was marked as rarely or never understood and that he was severely impaired in making decisions regarding tasks of daily life.</p> <p>Observation and interview on 02/11/2025 at 11:49am, revealed Resident #14 was in bed. His oxygenator reflected 8L/min and he was receiving a respiratory treatment at the time. He was on oxygen through his trach. Resident #14 appeared comfortable and without distress. Later observation on 02/11/2025 at 3:48pm, revealed Resident #14's oxygenator reflected 8L/min. LVN A came into the room and confirmed that Resident #14's oxygenator reflected 8L/min and said she was going out of the room to confirm Resident #14's oxygen orders with LVN B who was his nurse. LVN A came back and confirmed Resident #14 was supposed to be on 6L/min and adjusted his oxygen level. Resident #14 appeared comfortable and without distress during the observation.</p> <p>Interview with RN C and LVN B on 02/11/2025 at 3:48pm, LVN B said she was Resident #14's nurse. She said the oxygenator might've jumped up due to the machine's compressor shaking but that nothing was wrong with the machine. RN C said that Resident #14 had normal oxygen saturation and that Resident #14's oxygenator reflected 6L/min when she checked on him two hours ago. LVN B said as nurses they had to follow physician's orders and that exceeding physician's orders for oxygen could place residents at risk of distress. She said she received training on oxygen since working at the facility.</p> <p>Resident #43</p> <p>Record reviewed of Resident #43's Facesheet captured date of 02/12/2025 revealed Resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident's diagnosis included but were not limited to obstructive sleep apnea (disorder characterized by repeated episodes of complete or partial blockage of the upper airway, leading to disrupted breathing patterns during sleep), acute on chronic diastolic (congestive) heart failure (heart muscle's difficulty relaxing), cerebrovascular disease (disruptions in blood flow and oxygen supply to the brain), peripheral vascular disease (narrowed or blockage, reduced blood flow to the limbs), emphysema (shortness of breath), dementia, and acute cough.</p> <p>Record review of Resident #43's Care Plan captured date of 02/13/2025 revealed resident had an activities of daily living (ADL) self-care performance deficit with weakness, decreased mobility due to and chronic heart failure are all conditions that can affect the heart and lungs, and chronic obstructive pulmonary disease, peripheral arterial disease, and dementia with poor safety awareness. Date Initiated: 05/04/2023. Revision on: 10/17/2023. Resident was resistive to care, on compliant with oxygen tubing to be laces in bag after use and stored properly. Resident wraps tubing to bed post. Date Initiated: 02/11/2025. Revision on: 02/11/2025.</p> <p>Record review of Resident #43's MDS dated [DATE] revealed Resident had a BIMS of 14 suggesting that the resident's cognition was intact.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #43's Order Entry dated 07/06/2023 revealed Prescriber written/ordered by MD G. Description: Change Tubing: by way of (via) (Nebulizer tubing). Order Summary: Change Tubing: via (Nebulizer tubing) at bedtime every Thursday for maintenance after use detach, rinse, and allow to dry, and place in a bag. And, every 24-hours as needed for maintenance After use detach, rinse, and allow to dry, and PLACE IN A BAG.</p> <p>Observation/Interview on 02/11/2025 at 09:50 a.m., revealed O2 tubing on floor near garbage and bed of Resident #43. Resident #43 sat at bedside in wheelchair, oxygen was not in use.</p> <p>Observation/Interview on 02/11/2025 at 10:44 a.m. Family #1 stated that Resident #43's used PRN oxygen. Observed tubing on the floor, unlabeled.</p> <p>Observation/Interview on 02/11/2025 at 01:03 p.m. O2 tubing on floor in Resident #43's room. Resident #43 stated that he used oxygen all the time but could not provide a date and time of last use.</p> <p>Resident #86</p> <p>Record reviewed of Resident #86's Facesheet captured date of 02/13/2025 revealed Resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident's diagnosis included but were not limited to aortic aneurysm (balloon-like bulges that occur in the aorta) of unspecified site, without rupture (balloon-like bulges that occur in the aorta. Aorta is the main blood vessel through which oxygen and nutrients travel from the heart to organs throughout your body), spinal stenosis (the space within the spine that houses the spinal cord and nerve roots, becomes narrowed), cervical region, and dementia, unspecified severity, without behavioral disturbance.</p> <p>Record review of Resident #86's MDS dated [DATE] revealed Resident had a BIMS of 03 suggesting that the resident's cognition was severely impaired.</p> <p>Record review of Resident #86's Order Summary dated 02/08/2025 revealed: Oxygen at 2-liters per minute (LPM) via (nasal cannula) every 4-hours as needed for shortness of breath (SOB). Verbal order received from medical doctor (MD) G.</p> <p>Record review of Resident #86's Progress Notes dated 02/08/2025 at 06:42 p.m. Change of Condition Signs/Symptoms Details: SOB, started 02/08/2025, since started it has gotten: Things that make the condition worse: Things that make the condition better: History: Primary Diagnosis Vitals: Blood Pressure: 134/68 Lying down 02/08/2025 Pulse: 77 Regular 02/08/2025 Resp: 20 02/08/2025 Temp: 97.9 02/08/2025 . O2 Sat: 93 02/08/2025 2. Functional Status: Functional Status Changes: 1 Mentals Status: Mental Status Changes:1 Respiratory: 01, Cough: 00. Describe signs and symptoms (S/S): Assessment/Suggestion: Nebulizer (Neb) treatment every (q) 6 hours times (X) 3-days, as needed (PRN) oxygen at 2-LPM.</p> <p>Record review of Resident #86's Progress Notes dated 02/08/2025 06:55 p.m. Resident observed SOB, O2 sat 93% Nurse .received order for PRN oxygen at 2 liters (L) of Neb treatment (q) 6hr X 3 days.</p> <p>Record review of Resident #86's Progress Notes dated 02/09/2025 at 05:46 p.m. Resident is stable, no acute distress noted, Day 3/3 Phenol Aerosol related to (r/t) cough, no adverse reactions noted, no respiratory distress noted, Resident is currently on oxygen 2 L for SOB. no complaints of (c/o) pain or discomfort, will continue to monitor.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 02/11/2025 at 10:33 a.m. Resident #86 lying in bed not able to be aroused by voice. Oxygen tubing observed on the floor near bed.</p> <p>In an observation on 02/11/2025 at 01:16 p.m. Resident #86 was sitting at bedside in wheelchair. Oxygen tank on, facemask on bed and tubing on the floor. Resident picking at his meal tray food. Resident spoke words that were not understood.</p> <p>In an observation/interview on 02/11/2025 at 03:19 p.m. Registered Nurse (RN) H, stated that the resident's oxygen tubing should be bagged and placed away when not in use to prevent infections. She stated that it was also to be labeled with the date it was last changed. She stated it was hers and the certified nursing aids (CNA)'s responsibility to ensure that tubing was off the floor, labeled and bagged when not in use. RN H was observed labeling bags for Resident #43 and Resident #86's oxygen tubing.</p> <p>Record review of the facility's Monitoring of Medication Administration last revised 10/01/2019 reflected in part, procedures, personnel, and techniques are monitored, and that medications are administered at the frequency and times indicated in the prescriber orders.</p> <p>Record review of Resident #21's face sheet dated 02/11/25 revealed a [AGE] year-old admitted to the facility on [DATE] and again on 12/12/24. The resident's diagnoses included the following: dementia (memory loss and judgment), cerebral palsy (abnormal brain development often before birth that causes disorder of movement, muscle tone, or posture), epilepsy (uncontrolled jerking, loss of consciousness, blank stare), and dysphagia (difficulty swallowing).</p> <p>Record review of Resident #21'quarterly MDS dated [DATE] reflected a BIMS score of 9 which indicated the resident's cognition was moderately impaired. Review of section O (special treatment program) of the MDS reflected that the resident was receiving respiratory treatment.</p> <p>Record review of Resident #21's care plan dated 02/07/25 reflected the resident was care planned for infection of the respiratory tract with the intervention to administer antibiotics as ordered by the MD.</p> <p>Record review of Resident #21's Physician's Order Summary Report for the month of February 2025 reflected the following orders:</p> <p>-Dated 02/05/25 Ipratropium-Albuterol (medication used to treat respiratory disease by relaxing the muscles around the airways to open up and bake breathing easier) solution 0.5-2.5 (3) mg/3ml, 3ml inhale orally every 4 hours as needed for SOB or wheezing for 7 days via nebulizer (a small machine that turns liquid medicine into a mist that can easily be inhaled).</p> <p>-Dated 02/06/25 Doxycycline (medication used to treat bacterial infections in many parts of the body) oral tablet 100mg give 1 tablet by mouth twice a day for PNA (respiratory infection) for 7 days.</p> <p>Record review of Resident #21's MAR and TAR for the month of February 2025 reflected that the facility was following physician's orders.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 2/11/25 at 10:05AM revealed Resident #21 resting in bed. The resident had a wheelchair in the room on the left side of bed with clear tubing hanging on the back of the wheelchair with a mask attached to the tubing. Observation was made of the nebulizer machine sitting on the floor on the left side of the resident's bed at the head of bed.</p> <p>Resident #17</p> <p>Record review of Resident #17's face sheet dated 02/11/15 revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #17's diagnoses included the following: dementia (memory loss and judgment), Alzheimer's Disease (progressive disease that destroys the memory and other mental functions), mild intermittent asthma (when a person's airway becomes irritated, narrow and swell, producing extra mucus, which makes it hard to breathe), and chronic obstructive pulmonary disease (a group of lung disease that block airflow making it hard to breathe).</p> <p>Record review of Resident #17's quarterly MDS dated [DATE] reflected a BIMS score of 1 indicating the resident's cognition was severely impaired. Further review revealed the resident was receiving special treatment that consisted of respiratory treatments oxygen: continuous and non-invasive mechanical ventilator: breathing support device that uses a mask to deliver air to a patient's lungs to help breathe better.</p> <p>Record review of Resident #17's care plan dated 02/10/25 reflected the resident was care planned for a respiratory infection with the intervention to administer antibiotic as order by the MD.</p> <p>Record review of Resident #17's Physician's Order Summary Report for the month of February 2025 reflected the following orders:</p> <p>-Dated 02/10/25 Amoxicillin (medication used to treat bacterial infections, such as chest infections including pneumonia) 500-125mg give 1tablet by mouth three time a day for PNA (respiratory infection).</p> <p>-Dated 02/10/25 Ipratropium-Albuterol solution (medication used to treat respiratory disease) 0.5-2.5 (3) mg/3ml, 3 ml inhale orally every 4 hours as needed for SOB or wheezing via nebulizer (a small machine that turns liquid medicine into a mist that can easily be inhaled).</p> <p>Record review of Resident #17's MAR and TAR for the month of February 2025 reflected that the facility was following physician's orders for the above orders.</p> <p>Observation on 02/11/25 at 10:35AM revealed Resident #17 awake in bed coughing. The resident said she had bronchitis. The resident had an oxygen machine on the right side of bed with undated oxygen tubing connected to the machine that was lying on the floor on the right side of the resident's bed There was a nebulizer machine on the nightstand on the right side of the resident's bed with tubing connected to a nebulizer machine with a mask attached. The mask and tubing were not dated but the mask was inside of plastic bag.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Mememorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 Blalock Houston, TX 77055	
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 02/11/25 at 11:15AM revealed Resident #17 in bed with oxygen tubing still on floor. LVN Z was asked to go to resident's room to assess the resident. LVN Z went to Resident #17's room to check her oxygen saturation (the percentage of oxygen carried by red blood cells in the body). The resident's oxygen saturation was 94% on room air. LVN Z left the resident's room with the oxygen tubing still on the floor. The resident said she was okay and was not experiencing any difficulty breathing.</p> <p>Resident #11</p> <p>Record review of Resident #11's face sheet dated 02/11/25 revealed an [AGE] year-old male admitted to the NF on 08/14/24. Resident diagnoses included Type 2 diabetes mellitus (too much sugar in the blood), polyosteoarthritis (arthritis affecting five or more joints at the same time), glaucoma (eye condition that can cause blindness), hypertension (high blood pressure), and difficulty walking.</p> <p>Record review of Resident #11's quarterly MDS dated [DATE] reflected a BIMS score of 11 indicating the resident cognition was intact. Further review revealed the resident was on specialized treatment for respiratory care (non-invasive mechanical ventilator: breathing support device that uses a mask to deliver air to a patient's lungs to help breathe better).</p> <p>Record review of Resident #11's care plan dated 08/14/24 did not reflect a care plan for respiratory treatments.</p> <p>Record review of Resident #11's Physician Order Summary Report for the month of February 2025 reflected the following order:</p> <p>-Dated 02/10/25 Ipratropium-Albuterol (medication used to treat respiratory disease) 0.5-2.5 (3) mg/3ml, 3 ml inhale orally every 4 hr as needed for SOB or wheezing via nebulizer (a small machine that turns liquid medicine into a mist that can easily be inhaled).</p> <p>Record review of Resident #11's MAR and TAR for the month of February 2025 revealed that the facility was administering the medication Ipratropium-Albuterol 0.5-2.5 (3) mg/3ml, 3ml as ordered.</p> <p>Observation on 02/11/25 at 10:40 AM revealed Resident #11 had a rolling walker on the left side of his bed. Further observation revealed a mask connected to tubing lying on the rolling walker. The tubing and mask were not dated or inside of a plastic bag.</p> <p>Interview on 02/11/25 at 10:46 AM LVN Z said she was the nurse for Resident #11, Resident #17, and Resident #21. LVN Z said she had given Resident #17 a breathing treatment between 8:30AM or 9:00AM and that Resident #17 received breathing treatments three times a day. LVN Z said she worked from 7am-7pm.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation on 02/11/25 at 2:05 PM with LVN Z., regarding respiratory equipment (tubing, mask, etc.) said the respiratory equipment should be dated to signify when the last time the equipment had been changed for infection control. LVN Z said she believed respiratory equipment should be changed every seven days on the night shift; at least that was the way it was done at other facilities but was not for certain how it was done at the present facility. LVN Z said she worked at the NF PRN. LVN Z said because she worked at the present facility on a PRN basis, it did not give an excuse as to why respiratory equipment was not being labeled and placed in a plastic bag when not in use. LVN Z said she was the nurse for Residents #11, #17, and #21 and she must have overlooked the residents' respiratory equipment. LVN Z went to Resident #11 and Resident #17's room where she observed Resident #17's oxygen tubing still on the floor and Resident #11's nebulizer tubing with the mask sitting on the resident's rolling walker at the bedside. LVN Z placed on gloves and began to dispose of respiratory equipment by placing inside of a plastic bag and removing from the room of Resident #11's room. LVN Z said she would replace the respiratory equipment with new equipment, which she did including Resident #21.</p> <p>Interview on 02/11/25 at 2:20PM the DON said all respiratory equipment such as masks were supposed to be inside of zip top bag when not in use. The DON said the equipment should be dated and changed weekly usually on the night shift and as needed for infection control. The DON said the nurses were responsible in changing respiratory equipment. The DON said the unit managers and ambassadors assigned to certain rooms were to follow-up to ensure that this was being done.</p> <p>Review of the facility provided policy on Oxygen Safety dated 01/26/24 reflected in part:</p> <p>.It is the policy of this facility to provide a safe environment for residents, staff, and the public .</p> <p>The policy did not reflect oxygen supplies when to be dated and bagged when not in use.</p> <p>44669</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822</p> <p>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 disease and infections and follow standard and transmission-based precautions to be followed to prevent spread of infections for 1 of 24 (Resident #14) residents reviewed for infection control.</p> <p>During tracheostomy care for Resident #14, RN A and LVN B failed to properly dispose of used materials in a biohazard bag after completing care.</p> <p>This failure could put residents at risk of exposure to infection and cross contamination.</p> <p>Findings included:</p> <p>Record review of Resident #14's face sheet last captured 02/13/2025 revealed a [AGE] year-old male originally admitted on [DATE]. His medical diagnoses included anoxic brain damage (brain damage from lack of oxygen), muscle wasting and atrophy, cognitive communication deficit, tracheostomy status, chronic congestive heart failure, and pneumonia (infection of the lungs).</p> <p>Record review of Resident #14's Comprehensive MDS dated [DATE] revealed that he was receiving oxygen therapy at the facility.</p> <p>Record review of Resident #14's BIMS (a short assessment to determine a person's cognitive intactness) assessment dated [DATE] revealed a score of 0, indicating Resident #14 had severe cognitive impairment. He was marked as rarely or never understood and that he was severely impaired in making decisions regarding tasks of daily life.</p> <p>Record review of Resident #14's baseline care plan dated 02/09/2025 revealed he was receiving oxygen therapy, with interventions including monitoring for s/sx of respiratory distress and report to MD PRN.</p> <p>Record review of Resident #14's care plan last updated 02/10/2025 revealed he was had a focus area of having oxygen therapy r/t ARF and trach (tracheostomy, a surgical procedure that creates an opening in the windpipe to provide an airway for breathing) placement with a last revised date of 02/11/2025. Interventions included o2 via as ordered and position resident to facilitate ventilation.</p> <p>Record review of Resident #14's Physicians Orders last updated 02/11/2025 at 3:36pm revealed he had an order with a start date of 02/08/2025 for Oxygen at 6LPM (liters per minute) via trach every shift for hypoxia.</p> <p>Observation on 2/13/2025 at 8:53am of Resident #14 revealed RN A and LVN B completed tracheostomy suctioning. RN A exited Resident #14's room. LVN B brought a clear trash bag, placed supplies used for suctioning including gauze, sterile and non-sterile gloves, and a tracheostomy inner tube, with bodily fluids on them in the bag, tied it and placed it in a large, yellow container used for linen located in Resident #14's restroom.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 2/13/2025 at 11:42am with LVN B, she said that Resident #14's body fluids should have been put in her biohazard bag and disposed of immediately. If it was in a regular bag, LVN B said that staff or residents would not know how to properly handle biohazard material since they did not know what it contained. That could cause infection control issues because it was infectious to leave a room with fluids in a regular bag instead of a biohazard bag.</p> <p>Interview on 2/13/2025 at 2:36 with RN A, she said she was going to double-bag Resident #14's trash with a clear bag and then place it in a biohazard bag and take it to the biohazard room in the soiled utility room. RN A said the bag contained body fluid and sputum which would have been in the biohazard bag. She said not doing placing biohazard supplies in a biohazard bag before exiting a resident's room could have caused exposure to a respiratory illness.</p> <p>Record review of the facility's Equipment Protocol policy undated reflected in part, reusable items potentially contaminated with infectious materials shall be placed in an impervious clear plastic bag. Label bag as CONTAMINATED and place in the soiled utility room for pickup and processing.</p> <p>44669</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48923</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents for 2 of 2 (Residents #23, #50) resident rooms reviewed for environment.</p> <p>Resident #23 had a live roach in their bed during medication pass</p> <p>Resident #50 had a spider on the wall in their room near the bed .</p> <p>This failure could lead to spread of disease and a decline in resident health from preventable pest control.</p> <p>Findings included:</p> <p>Observation of medication pass on 2/12/2025 at 8:00am in Resident #23's room, a live roach crawled on the side of their bed. LVN G was observed using the face towel to brush the roach away during G-tube (gastric tube for nutrition and medication) medication administration.</p> <p>Observation and interview on 2/11/2025 at 9:31am in Resident #50's room, there was a spider on the wall by the right corner of Resident #50's bed. CNA B put on gloves and took a white towel and pressed on the spider. CNA B said that she will report this and that reports about pests are to be reported in the facility's computer system. She said the facility has spiders did appear and the facility gets pests when it's raining.</p> <p>Interview with the DON on 2/11/2025 at 3:09pm, she said she was made aware of the roach on Resident #23's bed during patient care and said that pest control did rounds and did not have any recent concerns with pests.</p> <p>Interview with the Maintenance Director on 2/11/2025 at 3:16pm, he said that he received work orders through the computer which he checked daily, which included pests. He said some staff are referred to as ambassadors and they made rounds each morning and throughout the day and are to report any environmental issues they observed. He said that he did not have any concerns regarding pests recently but saw a concern in the system today related to a spider seen in a resident's room earlier on 02/11/2025. The Maintenance Director said he went into that particular room but did not observe any pests but he called pest control who will come on 2/12/2025.</p> <p>Record review of the facility's Pest Control binder revealed Pest Control visited on 1/9/2025, 1/23/25 and 2/12/2025. There were no sightings of roaches or spiders. There were some light ant activity and small and large flies found in 5 of 5 light traps at the facility.</p> <p>Record review of the facility's policy on General Housekeeping, undated, reflected in part, the facility provides sufficient housekeeping and maintenance personnel, equipment, and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner.</p>		