STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676263	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerbrook Skilled Nursing and Rehab Center	9250 Humble-Westfield Rd Humble, TX 77338

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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 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** 38644 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #21) of 5 residents reviewed for care plans. The facility failed to ensure Resident #21's fall mat was at the bedside according to her care plan. This failure could place residents at risk of injury. The findings include: Record review of Resident #21's face sheet dated 2/28/25 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included Alzheimer's disease, schizoaffective disorder, bipolar type, anxiety disorder, drug induced subacute dyskinesia (abnormal involuntary movements), and abnormal posture. Record review of Resident #21's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. Staff assessed her mental status as severely impaired. She required assistance from staff with ADL care. She had two falls without injury since Admission/Entry or Reentry or Prior Assessment (whichever is more recent). Record review of Resident #21's care plan last reviewed 2/21/25 revealed she had actual falls related to dementia, gait/balance problems and incontinence. Interventions were to have bilateral (two sides) floor mats, date initiated 10/21/24. In an observation and interview on 2/27/25 at 11:49 a.m. of Resident #21 revealed she was lying in bed. There were no fall mats on either side of her bed. She said she fell out of bed but not recently. She said when she first arrived at the facility there were floor mats but it stopped. In an interview on 2/28/25 at 12:37 p.m. the DON said interventions on the care plan should be followed. She said if a fall mat was listed on Resident #21's care plan it should be out. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 2/28/25 at 12:40 p.m. of Resident #21's room with the DON revealed Resident #21 was lying in bed. There were no fall mats at the bedside. In an interview on 2/28/25 at 1:10 p.m. with Resident #21's assigned nurse, LVN A. She said she was unsure if Resident #21 needed a fall mat and would have to review the care plan. She said the resident fell out of the bed before and tried to get up sometimes. She said she had not seen fall mats in her room. She said the aides could review the Kardex/tasks on PCC to determine if the resident required a fall mat. She said the fall mat did not pop up in the physician orders. In an interview on 2/28/25 at 1:31 p.m. CNA C said Resident #21 could use a fall mat because the resident thought she could get up and go to restroom and would sometimes put her foot out of the bed. She said she had not seen a fall mat in the room this week. In an interview on 2/28/25 at 1:39 p.m. with Resident #21's assigned CNA, CNA V. She said Resident #21 had a fall mat a couple of months ago when she was in a different room. She said the resident moved to a different room, but the mats did not go with her, and was unsure why. She said the resident used to try to get out of bed a lot but did not try to get out as much now. She said she occasionally swung her legs. She said the Kardex (care plan chart or template) would inform her if a resident needed a fall mat. In an interview on 2/28/25 at 4:15 p.m. the Administrator said the purpose of the care plan was to outline the plan of care on a person-centered basis in accordance with the residents' unique requirements of care. She said the nurses reviewed the care plan and the POC should also have the requirements of care for the resident. She said it had been 2-3 months since Resident #21's last fall and nurses should ensure the fall mat was in place. Record review of the facility's Care Planning - Interdisciplinary Team policy dated September 2013 read in part, .our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. Record review of the facility's Falls - Clinical Protocol policy dated April 2007 read in part, . treatment/management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .

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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** 38644 47722 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADL's) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 3 of 5 residents (Residents #50, #84 and #82) reviewed for ADL's. The facility failed to ensure Resident #50 and Resident #84 received showers per facility schedule. The facility failed to ensure Resident #82 was provided fingernail care. This failure could place residents at risk for infection, discomfort, and dignity issues. Findings included: Record review of Resident #50's undated face sheet revealed he was an [AGE] year-old male admitted originally on 6/16/24, with the most recent admission being 2/10/25. He had diagnoses of osteomyelitis (bone infection caused by bacteria or fungi), muscle weakness, difficulty in walking, type 2 diabetes mellitus, COPD, absence of right toes, and peripheral vascular disease (a slow and progressive disorder of the blood vessels). Record review of Resident #50's Admission MDS dated [DATE] revealed a BIMS score of 4 out of 15, which indicated he had severely impaired cognition. He had impairment on both sides of his lower extremities and used a wheelchair. Resident #50 was substantial/max assistance (helper does more than half the effort) with shower/baths. He was frequently incontinent of bladder and bowel. According to the MDS, Resident #50 had diabetic foot ulcers and was on IV antibiotics. Record review of Resident #50's Care Plan dated 2/11/25 revealed he had an ADL self-care performance deficit r/t weakness and would improve the level of function through the review date. Interventions revealed he was substantial/max assistance with bathing. Record review of Resident #50's shower sheet from 2/1/25 through 2/27/25 revealed 1 response of Yes to the question, Did you bathe the resident? on 2/25/25 between 2/10/25 to 2/26/25. In an observation and interview on 2/24/25 at 10:14 a.m., revealed Resident #50 was sitting in a wheelchair in his room with his right foot bandaged and in a boot. He was very hard of hearing and had to communicate via writing on a piece of paper. Resident #50 said he had not had a bath/shower since he had been at the facility. 2. Record review of Resident #84's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of acute respiratory failure, muscle weakness, abnormalities of gait and mobility, cerebral infarction (stroke), and COPD. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #84's Admission MDS dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. The resident had impairment on both sides of his upper and lower extremities and used a wheelchair. He was dependent (helper does all of the effort) with all ADL's. The resident was frequently incontinent of bowel and bladder. Record review of Resident #84's Care Plan dated 1/14/25 revealed he had an ADL self-care performance deficit r/t weakness that he would improve through the review date. Interventions included being dependent with bathing. Record review of Resident #84's shower sheet from 2/1/25 through 2/27/25 revealed 1 response of Yes to the question, Did you bathe the resident? on 2/4/25 between 2/1/25 and 2/19/25. Record review of the February 2025 Grievance Log revealed Resident #84's family member filed a grievance on 2/19/25 about the resident not receiving showers. In an observation and interview on 2/24/25 at 9:41 a.m., revealed Resident #84 was sitting in a wheelchair and had limited mobility of his arms/hands. Resident #84 and his family member said he had not received a shower in 2 weeks. He said he had a stroke, and he forgets to ask for a shower and then they didn't give him one. In an interview on 2/28/25 at 1:00 p.m., Resident #84 said his shower days were Tuesday/Thursday/Saturday. He said he had received 2 showers the day before on 2/27/25. In an interview on 2/28/25 at 1:06 p.m., CNA O said the shower schedule depended on if the resident was at the front of the hall or the back of the hall, and if they were A bed or B bed. She said they gave their residents showers/baths on the 200 hall. In an interview on 2/28/25 at 1:08 p.m., LVN B said the even numbered rooms received showers on Monday/Wednesday/Friday and the odd numbered rooms received showers/baths on T/Th/S. The beds by the door received them on the day shift and the beds by the window received them on the night shift. She said a resident could always ask for a shower/bath on their off day and they would try to accommodate them. She said if a resident did not get a shower/bath they could get an infection. In an interview on 2/28/25 at 4:10 p.m., the ADM said she expected staff to give showers/baths as they were scheduled or requested, and there were enough staff to provide all of them. She said Resident #84's family had spoken to her about the resident not receiving showers/baths and she took care of the issue. She said if residents were not getting showers/baths it was a dignity issue and they could get skin breakdown or skin irritation. In an interview on 2/28/25 at 4:31pm, the DON said she expected the staff to give showers/baths on the resident's scheduled days. She said she had not had any CNAs told her that they did not have time or needed help. She also said during Angel rounds they checked to ensure residents looked clean and presentable and should have known if residents were showered or not. The DON said Resident #84's family told her that he had not had a shower/bath in 2 weeks. She said she took care of the issue, and he received a shower on 2/27/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of Resident #82's face sheet dated 2/27/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included right hand contracture (structural changes to your soft and connective tissues that cause them to stiffen, tighten and contract), muscle weakness, type 2 diabetes, and cerebral infarction (stroke). Record review of Resident #82's quarterly MDS assessment, dated 12/13/24 revealed a BIMS score of 0 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care. Record review of Resident #82's care plan reviewed 12/2/24 revealed she had an ADL self care performance deficit related to CVA ((stroke), weakness. Interventions indicated she was dependent with bathing and required partial/moderate assistance with personal hygiene. Observation on 2/25/25 at 10:01 a.m. of Resident #82 revealed her fingernails on both hands were about 0.3 cm long and had a brown substance underneath the nails, the nails appeared dirty. Her right hand was contracted and was in a semi-closed position. She smiled but did not respond when asked if she would like her nails cut. In an observation and interview on 2/27/25 at 1:08 p.m. CNA V observed Resident #82's nails and said they were too long, not clean, and needed care. She said it had been approximately one or two months since she last clipped Resident #82's nails. She said she worried that her nails could dig into her contracted hand. She said she previously asked for nail supplies but there were no clippers, files or sticks available in the facility. In an observation and interview on 2/27/25 at 1:18 p.m. LVN C observed Resident #82's nails and said they were very long and needed to be cut and cleaned. In an observation and interview on 2/27/25 at 1:28 p.m. of the central supply room revealed there were nail supplies available in the desk drawer. Central Supply Staff said she never cut Resident #82's nails and primarily cut residents nails who went to the dining room. In an observation and interview on 2/27/25 at 1:32 pm the Administrator observed Resident #82's nails and said they should not be that long. In an interview on 2/28/25 at 12:32 p.m. the DON said the CNAs were responsible for monitoring and cleaning nails during showers. She said the nurses should cut the nails if the resident was diabetic. She said if nails were not clipped and cleaned it could cause injury and have an effect on infection control and hygiene. She said residents could get sick or injure themselves. In an interview on 2/28/25 at 12:50 p.m. LVN A said she never cut Resident #82's fingernails. She said the CNAs normally cut the residents nails and no aide notified her that Resident #82's nails needed to be cut. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Care of Fingernails/Toenails policy revised April 2007 revealed in part, .the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record review the facility failed to establish and 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 1 of 7 residents (Resident #207) reviewed for Infection Control. - LVN B failed to wear a gown when she gave an IV antibiotic to Resident #207, who was on EBP. This failure could place residents at risk of cross-contamination and infections. Findings included: Record review of Resident #207's undated face sheet, revealed he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of sepsis (infection throughout the body), type 2 diabetes mellitus (body does not produce insulin or resists it), acute prostatitis (infection of the prostate), and acute metabolic acidosis (too much acid in the blood). Record review of Resident #207's Admission MDS revealed it was not completed yet. Record review of Resident #207's Care Plan dated 2/15/25, revealed he was on EBP r/t an indwelling medical device (PICC line). The goal was to reduce the risk of infection through the next review. The interventions included wearing gloves and gown during high-contact care activities for a resident with indwelling [NAME] devices, wounds and colonized or infection with a CDC targeted MDRO. Also, sanitize hands before entering and leaving the resident's room. The care plan also said the resident had sepsis and would be free from complications related to the infection through the review date. Interventions included administering antibiotics, Cefazolin (type of antibiotic) IV via PICC line, and Ertapenem (type of antibiotic) IV via PICC line. Record review of Resident #207's Daily Skilled Note from 2/15/25 at 11:19am by LVN B revealed the resident was on IV Cefazolin and Invanz day 1 of 120 doses. The note also reflected the resident had a midline to his LUE. Record review of Resident #207's Physician Orders revealed the following orders from MD Q: - Cefazolin 2gm IV Q8hr for UTI. Ordered on 2/15/25 at 7:00am. - Ertapenem 1gm IV Q24hr for UTI. Ordered on 2/15/25 at 7:00am. - May insert PICC line to Left upper arm, one time only for 1 day. Ordered on 2/15/25 at 1:00pm. - PICC IV: Flush each lumen with 10ml of NS Qshift. Ordered on 2/15/25 at 2:00pm. - IV: Monitor IV insertion site for s/s of infection/infiltration Qshift. Ordered on 2/15/25 at 2:00pm. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- PICC IV: Change IV dressing Q7days and PRN. Every night shift on Sunday. Ordered on 2/16/25 at 10:00pm. - Enhanced Barrier Precautions-PPE: Gloves/Gown during high-contact resident care activities, every shift. Ordered on 2/19/25 at 2:00pm. In an observation and interview on 2/26/25 at 9:50am with LVN B, the resident had an EBP sign on his door. LVN B prepared her tray with the IV antibiotic she was going to give, an alcohol pad, and a saline flush. LVN B washed her hands and proceeded to enter the room. LVN B put on gloves and spiked the bag of Invanz 1gm/100ml with the IV set. She hung the bag on the IV pole and then cleaned and flushed Resident #207's PICC line with the saline flush. After she flushed the PICC line she connected the IV line to the resident's LUA PICC line and started the antibiotic. She did not wear a gown during the whole process. LVN B said she forgot to wear a gown and that she was supposed to wear a gown and gloves during IV administration. She said it was to protect the resident from cross contamination. In an interview on 2/28/25 at 4:10pm with the ADM, she said she expected staff to follow the policies for EBP. She said they were supposed to wear a gown and gloves when giving IV medication. She said the purpose was to protect the resident from being exposed to an infection and from staff getting an infection. In an interview on 2/28/25 at 4:31pm with the DON, she said she expected staff to wear a gown and gloves when doing patient care. She said staff were supposed to wear a gown and gloves when giving IV antibiotics because it prevents the spread of MDROs. Record review of the facility's policy and procedure on Enhanced Barrier Precautions (effective April 1, 2024) revealed in part: This policy outlines the guidelines and procedures to implement enhanced barrier precautions to prevent the spread of infectious diseases among residents and staff. Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities . EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: .Device care or use: central line . Indwelling medical device examples include central lines .