

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2026
NAME OF PROVIDER OR SUPPLIER Deerbrook Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9250 Humble-Westfield Rd Humble, TX 77338	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 6 residents (Resident CR# 1) reviewed for pressure ulcers.1. The facility failed to identify and provide wound treatment from 3/13/26 to 3/25/26 for CR #1 who experienced a decrease in skin integrity to the left hip that resulted in a stage 4 pressure wound, stage 3 pressure wound to the right sacrum, unstageable wound to the scrotum and an unstageable DTI of the right heel that were all identified on 3/25/26 by the wound care doctor. 2. The facility failed to complete a comprehensive skin assessment or initiate timely treatment orders for several significant pressure injuries for CR#1. Treatment orders were not obtained for multiple wounds until 03/25/26, approximately 12 days after admission. Additional wounds were not addressed until 04/15/26.3. The facility failed to turn/reposition Resident #13 every 2 hours as stated in the care plan, on 5/13 from 8:00 am-1:30 pm. This noncompliance was identified as non-immediate jeopardy. An Immediate Jeopardy (IJ) situation was identified on 05/14/2026. While the IJ was removed on 05/16/26, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of wound deterioration, infection and hospitalization. Findings included: Record review of CR#1's face sheet, dated 04/28/26, revealed a [AGE] year-old who was first admitted to the facility on [DATE]. CR #1 had diagnoses which included sepsis (blood infection), muscle wasting, anemia (deficiency of healthy red blood cells), malnutrition (lack of proper nutrition), Dementia (a decline in cognitive function), legal blindness, heart disease, COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway), partial intestinal obstruction, acute kidney failure, traumatic hemorrhage (bleeding) of brain. Record review of CR#1's admission MDS resident assessment, dated 03/17/26, revealed a BIMS score of 3 out of 15, which indicated severe cognitive impairment. CR#1 had impairment to both sides of the upper extremities. CR #1 was dependent on staff assistance for all ADLs. CR#1 had one unstageable deep tissue injury that was present upon admission and was receiving nutrition interventions to manage skin problems as well as pressure ulcer/injury care. Record review of CR #1's hospital records, dated 3/12/26, revealed a wound first assessed on 3/11/26 and present on original admission: pressure injury to the right posterior hip and a wound first assessed on 3/12/26: pressure injury to the left lateral foot, present on original admission. The CT of the abdomen and pelvis revealed a possible soft tissue abscess over the left lower pelvis or bursitis. CR #1 was receiving Zosyn 3.375g IV every 8 hours starting 03/12/26 for sepsis secondary to suspected skin/soft tissue abscess infection. Record review of CR #1's completed, discontinued, on hold orders with the date range: 02/28/26 to 04/30/26 revealed orders for: Zosyn 3-0.375gm/50ml IV every 6 hours for ischial (bony prominence of the lower pelvis) abscess until 3/24/26. Left lateral foot/DTI: skin prep to area three times a week daily and PRN, order date was 03/16/26. Further review revealed there were no additional treatment orders from 3/13/26 to 3/25/26 for the other wounds until orders were written on 03/25/26 for the following: Right medial (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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Continued hourly observations at 9:11 am, 10:35 am, 11:35 am, 12:35 pm, & 1:30 pm found Resident #1 lying on her back in the same position unmoved. Resident #13 was not turned and/or repositioned during the hours of 8:21 am-1:30 pm. During an interview on 05/13/26 at 9:11 am, Resident #13 stated she had not been turned all morning. She said the last time she had been turned was 3 days prior. She stated no one had attempted to turn her or even asked her all day. She mentioned she had recently healed from a wound on her sacrum (record review showed it was an unstageable pressure ulcer). She stated she was uncomfortable. She wanted to be turned & would not have refused. She said she did have pain when being turned. Resident said she was not able to turn herself because a car hit her and broke her back. During an interview with Resident #13 on 05/13/26 at 10:35 am, she stated she had not been turned and had not seen any staff. During an interview with Resident #13 on 05/13/26 at 11:35 am, she stated she had a staff member come in the room to take her blood sugar and give her medications, but no one turned her. During an interview with Resident #13 on 05/13/26 at 12:35 pm, she stated she had not seen any staff and had not been turned. During an interview with Resident #13 on 05/13/26 at 1:30 pm, she stated she had not been turned. She said CNA A just asked how she was and to refill her water and left the room. During an interview on 05/13/26 at 1:32 pm, CNA A stated that she had a list of which residents needed to be turned and how often. CNA A stated there were a couple of residents who refused all day to be turned. She stated Resident #13 does not like to be turned because it hurts her back. She said Resident #13 had even refused in the past. When told that Resident #13 had not been turned all day, she reiterated that Resident #13 does not like to be turned because it hurts her back and she stated Resident #13 had not asked to be turned. She stated the risks of a resident not being turned were skin breakdown & pain. She said that when a resident refused to be turned/repositioned she should notify a nurse because they chart refusals. She said she had not told a nurse Resident #13 refused. During an interview on 05/13/26 at 1:40 pm, Nurse A stated he was unaware of Resident #13 not being turned & that he was not told by CNA A that Resident #13 did not want to turn. He said that it was a CNA's responsibility, but it was the nurse's responsibility to ensure it was being done. He said that the risks were skin breakdown, pressure ulcers, rashes, discomfort, & pain. He said when a resident refused, nurses were to speak with the resident to find out why, encourage the resident, reeducate them on risks, chart the refusal, and notify the family and physician. During an interview on 05/13/26 at 3:33 pm, the DON stated that the CNAs knew who to reposition & when because it is in their tasks on electronic medical record. She said they can also know by looking at their residents to see if they look uncomfortable or have extra pillows. She stated if they were unsure they can always ask their nurse. She said staff were trained on repositioning/turning with check offs which were just completed last month (April 2026) & her goal was to have check offs done quarterly. She said that if a patient refused, her expectation was for a CNA to let a nurse know. The nurse should then go check with the resident to find out why. The nurse should encourage the resident to allow themselves to be turned/repositioned & reeducate them on the risks of not doing so. If they still refuse, the nurse should chart the refusal, contact the family, the physician, & care plan the refusals. She said her expectation is that all residents should be turned unless there is a contraindication. She said that the risks of not turning a resident are skin breakdown & pressure ulcers. Noncompliance with Resident #13 was found to be non-immediate jeopardy. Record review of the facility's policy for Wound Care, revised on December 2011, read in part: The purpose of (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure.Documentation: The following information should be recorded in the resident's medical record: 1. The date the wound care was given. 2. The initials of the individual performing the wound care. 3. Any change in the resident's condition. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the treatment and the reason(s) why. 6. The signature and title of the person recording the data. Reporting.2. Report other information in accordance with facility policy and professional standards of practice.Record review of the facility policy for Change in a Resident's Condition or Status, revised on December 2016, read in part: .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an).b. discovery of injuries of an unknown source.8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.This was determined to be an Immediate Jeopardy (IJ) on 05/14/2026 at 7:45 PM. The Administrator was provide with the IJ template on 05/14/2026 at 7:45 PM.The following Plan of Removal submitted by the facility was accepted on 5/14/26 at 11:43AM:Immediate action:G.CR#1 was discharged to the hospital on 4/24/2026.H.On 4/29/2026 Medical Director reviewed and approved the RCA and ADHOC facility implemented.I.On 4/29/2026 the Nurse Managers completed a facility-wide skin assessment audit for all current residents to identify undocumented wounds, untreated wounds, missing physician orders, and missing care plans. No concerns were identified.J.On April 29, 2026, the DON, ADON, Unit Manager, Weekend Treatment Nurse, and Treatment Nurse received a disciplinary action regarding failure to follow wound care policy.K.The Clinical Services Director reviewed facility policy on 4/29/2026 regarding the wound care policy and no revisions were deemed necessary. L. DON re-educated the nursing staff on pressure injury prevention and documentation on 4/29/2026.M.The DON/designee re-educated the CNAs on the Stop and Watch early warning tool on 4/29/2026.N.The Medical Director was notified of the IJ for F 686 at 8:30 pm on 5/14/2026. Facility's Plan to ensure compliance quickly`On 5/14/2026 the Corporate Clinical Services Director reeducated the DON, Nurse Managers, and Treatment Nurse on reviewing the 24-Hour report daily, admission checklist on all admissions, and the wound care policy.`All new admissions will receive a complete head-to-toe skin assessment upon admission by the admitting licensed nurse. Any identified skin alteration will require immediate physician notification, treatment orders, and documentation. To ensure compliance moving forward, the DON, Unit Managers, and Wound Care Nurse will oversee and monitor the admission skin assessment process. The DON, Unit Managers, CSD, and RVP will oversee and monitor compliance through daily review of the Skin Management System audit tool, including admission skin assessments, wound documentation, physician notifications, treatment orders, and care plans to ensure timely identification, treatment, and follow-through of all skin integrity concerns. Any identified concerns or deficiencies will be addressed immediately through corrective action, re-education, and ongoing follow-up monitoring to ensure sustained compliance. `The wound care nurse will complete a comprehensive skin assessment within 24 hours of admission. Any identified skin alteration will require immediate physician notification, treatment orders, documentation, and care plan initiation.`Licensed nursing staff (full-time, part-time, and PRN) were re-educated regarding skin assessments, physician notification, treatment initiation, documentation, and care planning requirements, completed on 5/14/2026 by the Nurse Managers. Newly hired nurses will be in-serviced by the Director of Nursing or designee on the Wound Care Policy. No licensed nursing staff will be allowed to work without receiving the in-service Wound Care Policy. `CNAs (full-time, part-time, and PRN) were re-educated on the Stop and Watch early warning tool, completed on 5/14/2026 by the Nurse Managers/designee. Newly hired CNAs will be in-serviced by the Director of Nursing or designee on the Stop and Watch early warning tool. No CNAS will be allowed to work without receiving the in-service.`A daily skin management system audit form was implemented on 4/29/2026 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Deerbrook Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9250 Humble-Westfield Rd Humble, TX 77338	
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and will be reviewed in the morning meeting to ensure orders, assessments, and care plans are initiated. The DON/designee will complete the daily skin management system audit form daily x 8 weeks. Quality AssuranceAn impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 5/14/2026 with the Medical Director. The Medical Director has reviewed and agrees with this plan. Monitoring of the POR included the following: Interview on 5/14/26 3:50PM, LVN C who worked day shift, was the primary wound care nurse said she reviewed the residents who were being seen by the wound care physician and completed an audit of the wound care physician's evaluations and resident care plans. Interview on 5/14/26 at 4:30PM, CNA E who worked day shift, stated wound care interventions included air mattress, turning every 2 hours, repositioning by use of wedges or pillows and keeping resident's skin clean and dry. CNA E stated she was trained to identify skin breakdown, to use the stop and watch forms and to notify the nurse. CNA E stated the risk of not implementing interventions would be further skin breakdown, infection and wound not healing. Observation on 5/16/26 at 1:25 PM, of wound care for Resident #45, RN T performed hand hygiene and put on appropriate PPE. Resident #45 was alert, oriented and lying on her right side on an air mattress. RN T removed the old dressing, the wound was large with a pink center, and the surrounding skin was appropriate skin color for the resident. Resident #45 denied pain. RN T cleansed the area with wound cleanser, dried area with gauze, applied the collagen sheet, calcium alginate, skin prep to the surrounding skin and applied the new border dressing. No issues were noted with the procedure or with infection control. RN T provided wound care as per physician orders. Interview on 05/16/26 at 2:10PM, CNA J stated she worked 2pm to 10pm shift and had recently received numerous in-services. CNA J stated that any time there is a change in skin or anything that is different on the resident, any open areas, scraps no matter what size she would report to her floor nurse and would always write a notification in duplicate and give to the nurse. CNA J stated she would document in PCC as well and the message would be seen by the Administrator but would always verbally notify her nurse first. CNA J stated the skin on the resident's bottom can be affected if not turned every 2 hours. CNA J stated turning every 1-2 hours would be most important to help prevent skin injuries and if a resident did have a wound and had been sitting up she would put the resident to bed after meals. CNA J stated prevention included thorough incontinent care because a wound can worsen quickly. CNA J stated she would get information about a resident's mobility assistance from the binder at the nurse station, from the Kardex, or from a verbal report from the nurse. CNA J stated for a newly admitted resident she would pay more attention to the skin on the buttocks and the feet. Interview on 05/16/26 at 2:36PM, LVN K worked 2 PM to 10 PM, stated she recently had an in-service regarding pressure ulcers and skin assessments. LVN K stated she was a certified wound care nurse but this was not her role at the facility. LVN K stated regarding new admissions she would ensure the resident was in bed, collect the paperwork, completed the head to toe skin assessment, check medications and then call the doctor. LVN K stated if a resident admits with wounds she would uncover the wound if the wound had a dressing then make her assessment; she would document the wounds accurately then put a communication note for the wound care nurse and place under the door to the wound care nurse office. LVN K stated if the resident did not have wound orders she would be responsible to notify the doctor and get orders. LVN K stated she may call the hospital if the resident did not come with paperwork from the hospital to find out if there were wound orders. LVN K stated it was her responsibility to document everything and to ensure the CNAs would complete their documentation and communicate with the nurses. Interview on 05/16/26 at 2:54PM, CNA L worked 2 PM to 10 PM, stated he had received many different in-services recently. CNA L stated residents were more prone to developing pressure ulcers if they were unable to reposition themselves. CNA L stated to prevent pressure ulcers he would reposition his residents every 2 hours and change their briefs often because moisture can cause skin breakdown and can make existing wounds worse. CNA L stated wounds develop quickly especially in older individuals. CNA L stated he would report any change in condition including skin changes such as redn		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on 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 #12) of 5 residents reviewed for care plans. The facility failed to ensure Resident #12's dentures were on her care plan. This failure could place residents at risk of unmet ADL needs. The findings included: Record review of Resident #12's face sheet, dated 5/13/26, revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included unilateral primary osteoarthritis, right hip (degeneration of cartilage in a single joint due to normal wear and tear without a known cause or underlying injury), schizoaffective disorder, bipolar type (mental health condition that combines symptoms of schizophrenia with episodes of mania or hypomania, and sometimes major depression), and unspecified dementia, moderate, with agitation. Record review of Resident #12's quarterly MDS assessment, dated 3/13/26, revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. She required supervision or touching assistance with oral hygiene. Record review of Resident #12's care plan last reviewed 3/16/26 revealed she had an ADL self-care performance deficit related to dementia. She required supervision or touching assistance with personal hygiene and oral hygiene. Her dentures were not documented on the care plan. In an interview on 5/12/26 at 3:53 p.m. Resident #12's family member said most of the facility staff could not deal with Resident #12's [NAME] body dementia (the second most common type of dementia). He said the hardest thing to get the staff to do was clean her teeth/dentures. He said staff told him the resident would bite them. During an interview on 5/15/26 at 6:27 p.m. CNA M said she provided care for Resident #12 for the last 2 months. She said the resident was very, very confused and combative. She said Resident #12 had (natural) teeth, did not wear dentures and she had never seen her with dentures. CNA M said the resident would not let her get inside of her mouth; she would fight or attack her. She said she never tried to get inside her mouth. CNA M said the morning shift staff never mentioned removing her dentures. CNA M said if the resident had dentures, she would remove them and place them in a cup with dental solution. She said the electronic medical record would alert her if the resident had dentures and she never saw dentures documented on the Kardex. She said dentures needed to be cleaned because food could get in there. During an interview on 5/15/26 at 6:43 p.m., the PPS Nurse said she was aware Resident #12 wore dentures because of the MDS assessment and because the family member asked the facility to remove them from her mouth and clean them. She said CNAs should be made aware of the dentures by the oral hygiene task indicated under ADL care. She said it would be more helpful to the CNAs if dentures were documented on the care plan, but it should be obvious to staff when providing oral hygiene. She said Resident #12's dentures should be care planned, and it was the tasks of the unit manager or herself to put it on there. During an interview on 5/15/26 at 7:34 p.m., the Unit Manager said she was aware Resident #12 wore dentures because she recalled the struggle of removing them from her mouth. She said new CNAs were informed of her dentures during training and orientation and oral care was also listed on the Kardex. She said she did not update the resident's care plan to include dentures, but it should be care planned, so staff knew she had them and for inventory purposes. She said the MDS nurse would have care planned her dentures. She said she did not foresee any risk to the resident of not having the dentures care planned. Record review of the facility's Care Plans - Comprehensive policy, dated December 2009, read in part, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident."		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 5 residents (Resident #7) reviewed for ADLs. The facility failed to ensure Resident #7 was provided with fingernail care. This failure could place residents at risk of infection and discomfort. Findings included: Record review of Resident #7's face sheet, dated 5/15/26, revealed a [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnoses included sepsis (life-threatening medical emergency caused by the body's overwhelming response to an infection), abnormalities of gait and mobility, and type 2 diabetes. Record review of Resident #7's significant change in status MDS assessment, dated 5/15/26, revealed a BIMS score of 13 out of 15 which indicated intact cognition. The functional abilities section was blank. Record review of Resident #7's care plan reviewed 4/5/26 revealed she had an ADL self-care performance deficit related to weakness. Her interventions read, (Resident #7) requires partial/moderate assistance with personal hygiene. During an observation and interview on 5/12/26 at 10:45 a.m., Resident #12's right index fingernail was long. She said she would love to have her fingernails cut but did not have the money. She said her thumb nail was rough and needed to be filed. In an observation on 5/13/26 at 8:41 a.m., RN K told Resident #12 her fingernails needed to be cut, and she would get a staff member to do her nails. Resident #12 replied, yes, that would be nice. In an observation and interview on 5/13/26 at 11:31 a.m. Resident #12's right index fingernail was long. She said her nails had not been cut. During an interview on 5/14/26 at 12:11 p.m., Resident #12 said her fingernails were not cut and needed to be. In an observation and interview on 5/15/26 at 12:02 p.m., LVN J observed Resident #12's fingernails. LVN J said the fingernails were too long and that Resident #12 also told her they were too long. She said nail care should be done on shower days. She said the nurse who previously observed the resident's nails should have addressed them at that time. She said she would cut and clean her nails. During an interview on 5/15/26 at 3:39 p.m., CNA S said she did not notice anything about Resident #12's fingernails when she worked with her and the resident did not ask for them to be cut. She said the Activities dept. would cut the fingernails and she had not personally cut any fingernails. She said no one told her she should cut fingernails. She said she would clean under the fingernails during a shower. She said resident nails should be right past the fingertip to prevent scratching and bacteria from getting under the nails. In an interview on 5/15/26 at 5:12 p.m., RN K said when she worked with Resident #12 on Wednesday (5/13/26), one of her fingernails was long and she informed the resident she would try to get someone to do her nails. RN K said nail care would be provided to the resident during her shower, and the CNAs were supposed to do their nails. RN K said she clipped fingernails all the time but Resident #12's nails were ok to wait until her shower day. In an interview on 5/15/26 at 6:12 p.m. the DON said fingernails should be trimmed during showers and nurses would do the nail care if the resident was diabetic. She said Resident #12's fingernail was long, but the resident liked the length but would accept trimming if someone provided it. She expected every resident to be offered nail care during baths, every day, or if needed. She said fingernail care was a part of ADL care and was the resident's right. She said nail care should be provided because of germs, different infections, and the risk of scratching, skin tears, and abrasions. Record review of the facility's Care of Fingernails/Toenails policy, revised April 2007, read 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 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** Based on observation, interview, and record review the facility staff failed to ensure residents with incontinent bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 resident (Resident #13) reviewed for incontinent care. The facility failed to ensure Resident #13 had a securing device in place for her urinary catheter on 05/13/26. This failure could place residents at risk for skin breakdown, pressure ulcers, infections, pain, and/or decline in quality of life/ADLs. Findings included: Record review of Resident #13's admission MDS assessment, dated 03/09/2026 revealed, a [AGE] year old female, admitted on [DATE], with a BIMS of 13, indicating intact cognition, and diagnoses included multiple fractures of the spine (broken vertebrae in the neck and back secondary to being struck by a vehicle while on foot), neurogenic bladder (lack of bladder control secondary to nerve damage), hypertension (high blood pressure), peripheral vascular disease (condition in which narrowed arteries reduce blood flow to the arms or legs), thyroid disorder (conditions that disrupt the normal function of the thyroid gland, affecting hormone production and metabolism), diabetes mellitus, hyperlipidemia (high cholesterol), & depression. During an interview on 05/13/26 at 9:11 am, Resident #13 stated she had not had a statlock on her catheter (a small, adhesive-based catheter stabilization device designed to securely hold medical tubing in place on the skin) since the day before. She said it must have come off when she had gotten a bath the day before because she remembered seeing it before then. Observation of Resident #13 on 05/13/26 at 9:17 a.m. revealed a foley catheter with privacy bag, 200mL of urine, & the absence of a statlock or any other device securing the urinary catheter to Resident #13's thigh. During an interview on 05/13/26 at 1:31 pm, CNA A stated she had not noticed there was no statlock on Resident #13's leg. She stated that replacing a statlock was a nursing responsibility, but it was her job to report it. During an interview on 05/13/26 at 1:40 pm, Nurse A stated that all residents with urinary catheters should have a statlock in place on the thigh. He stated that he did not notice that Resident #13 did not have a statlock in place that morning. He said that he must have overlooked it somehow. He said that it was a nurse's responsibility to place/replace a statlock and said he would take care of it. He said the risks of not having a catheter secured were the catheter pulling & causing injury, pain, discomfort, & UTI. In an interview on 05/13/26 at 3:33 pm, the DON stated that the facility did a sweep to ensure all statlocks were in place & that they checked every day. She said that statlocks were used to prevent injury, trauma, infection, for safety, & to keep the catheter bag off the floor. She said that CNAs & nurses get training on catheter care & they have check offs. She said nurses are responsible for ensuring statlocks are in place, but that sometimes CNAs notice & notify nurses. She said the risks of not having a statlock in place are injury, trauma, & infection. Record review of the facility policy titled, Catheter Care, UrinaryH5MAPR0048, dated 3/31/2016, indicated, under subsection ?Changing Catheters' Ensure that the catheter remains secured with a securement device such as a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.).		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse for 1 of 6 residents (Resident #6) reviewed for pharmacy services. The facility failed to ensure that Resident #6 was given medication by a licensed/certified staff member on 05/13/26. This failure could place residents at risk of not receiving the therapeutic benefit of the medication and/or worsening health concerns. Findings included: Record review of Resident #6's quarterly MDS assessment, dated 3/26/26, revealed, a [AGE] year-old male admitted on [DATE] with a BIMS of 9 which indicated moderate cognitive impairment. His diagnoses included hypertension (high blood pressure), diabetes mellitus, hyperlipidemia, thyroid disorder, & depression. During an observation of patient care on 05/13/26 at 10:00 am, CNA A was changing Resident #6's brief when Nurse A entered the room with a tube of zinc oxide ointment for Resident #6. Nurse A handed the tube to CNA A & asked her to apply it to Resident #6's buttocks & sacrum. CNA A did as asked & then Nurse A took the tube & left the room. CNA A finished patient care & then Resident #6 asked if there was any cream left because he was supposed to have it applied to his genitals as well. CNA A told Resident #6 that the nurse had already left & taken the cream with him. During an interview on 05/13/26 at 10:40 am, Resident #6 stated he was usually given his cream by a nurse. He said he had not gotten any other cream applied today (5/13/26) so he knew it was not applied to his peri area (the diamond-shaped area located between the thighs, extending from the pubic symphysis to the coccyx) where he was supposed to get it. During an interview on 05/13/26 at 1:31 pm, CNA A stated that she did not know which areas Resident #6 was supposed to have zinc oxide applied to because she was not a nurse & the nurse was who usually applied it. She said she forgot to ask Nurse A if Resident #6 was supposed to have cream applied to his peri area (genitals). She said that Resident #6 hadn't had any other cream applied that shift that she was aware of. She said she reported to the DON that the nurse had asked her to apply the cream. During an interview on 05/13/26 at 1:40 pm, Nurse A stated that zinc oxide is to be given by nurses. He said that he asked CNA A to do it that morning because he made a mistake & was thrown off that he walked into the room where patient care was already happening & a surveyor was there observing. He said that the order states to apply the cream once per shift to Resident #6's buttocks, sacrum, & peri area. He said that he had applied the cream to Resident #6's peri area that morning, but that Resident #6 was sleepy so maybe he wasn't aware I did it. He said it is the expectation to let residents know what medication they were being given & what it was for. He said the risks of a CNA applying ointment could be ineffective application, leading to skin breakdown & rashes. During an interview on 05/13/26 at 3:33 pm, the DON stated, after checking Resident #6's orders, that zinc oxide was a medication so it should be given by a nurse & not a CNA. She said a CNA is not qualified to give a medication & that the CNA should have refused the nurse's request & told him she wasn't allowed to give medication. She also stated that when the resident asked about the ointment being applied to his peri area, she should have notified the nurse so the nurse could assess to see if he needs the medication applied there. Her expectation was that nurses follow physician orders, give medications as ordered, & CNAs refused anything outside their scope of practice. She said the risks of having a CNA apply the ointment were it being applied incorrectly or to the wrong area resulting in the medication being ineffective & leading to skin breakdown.		