STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676305	A. Building B. Wing	10/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Stayton at Museum Way	2501 Museum Way Fort Worth, TX 76107

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview, and record review, the facility failed to identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one (Resident #2) of five residents reviewed for wounds. 1. RN A failed to remove the semi-occulsive dressing (a type of wound dressing that allows air to pass through while protecting the wound from liquids) that secured the negative pressure wound therapy ([NPWT] - wound vac) suction device and tubing over the wound. RN A pulled on the suction device and tubing to remove the old dressing that caused Resident #2 pain and discomfort on 10/26/24. 2. RN A failed to follow the facility's general procedure for wound vac dressing change on 10/26/24. RN A obtained foam dressings from a drawer in Resident #2's room. The foam dressings were non-sterile due to being stored in an opened or undamaged package. RN A did not trim the foam dressing to dimensions that allowed the foam to be placed into the wound bed. RN A applied the foam dressing to the wound and overlapped onto intact skin around the wound. 3. RN A failed to follow facility protocol and don a gown in addition to gloves to reduce the risk of transmission of bloodborne pathogens and apply enhanced barrier precautions (EBP) when he performed wound vac dressing change to Resident #2's right knee on 10/26/24. 4. RN A re-used the wound vac disposable components (suction device and tubing) when he performed wound vac dressing change to Resident #2's right knee on 10/26/24. 5. RN A failed to follow physician orders to apply an ointment as ordered to the surrounding skin around Resident #2's right knee wound on 10/26/24. 6.The facility failed to perform weekly skin assessments for Resident #2 on 10/21/24. These failures placed residents with wounds at an increased risk of infection, wound contamination, unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and failure of the wound to heal. Findings included: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #2's Admission Record printed 10/26/24 revealed the resident was a [AGE] year-old female admitted on [DATE]. Resident #2 had diagnoses of unspecified fracture of lower end of right tibia; Unspecified open wound, Right knee, Sequela (a condition that results from a previous illness, injury, or medical intervention); and Infection and Inflammatory reaction due to internal right hip prosthesis, subsequent encounter (routine care during the healing or recovery phase after active treatment was received for a condition). The Admission Record reflected 13 days length of stay. A record review of the Comprehensive MDS Admit assessment dated [DATE] reflected Resident #2's BIMS score was 15, which indicated intact cognitive response. The Comprehensive MDS Admit Assessment reflected Resident #2 needed partial assistance from another person to complete ADLs. Section M - Skin conditions revealed Resident #1 was not at risk for developing pressure ulcers/injuries and surgical wound(s) were present on admission. A review of Resident #2's hospital discharge clinical records dated 10/11/24 revealed final discharge instructions that included discharge medications; diet type; Activity: Non-weightbearing to right leg; Wound/Dressing Care: do not submerge incision. Keep wound clean and dry. Perform pin site care daily. Mix 1/2 Peroxide and 1/2 Normal Saline and use gauze to clean around pin sites; Follow up with PCP in 1 week after discharge (from hospital); Follow up in 2 - 3 weeks with orthopedic surgeon; Follow up in 1 - 2 weeks with right ankle orthopedic surgeon; and Daily wet to dry dressing change right knee wound. Record review revealed a skin check on admission (10/14/24). There were no other skin checks, or a weekly skin assessment performed on Resident #2. Record review of Resident #2 progress notes dated 10/14/24 at 7:34 PM, revealed right lateral knee trauma wound 1.2 cm x 1 cm x 0.1 cm (LxWxD) 90% granulation with moderated serosanguinous drainage. Record review of Resident #2's care plan, initiated 10/16/24, reflected [Resident #2] had an alteration in musculoskeletal status r/t fracture of the right tibia and fibula, external fixator placed 10/09/24; had a chronic infection of the right hip after hip surgery; had actual impairment to skin integrity of the right knee - infection with previous surgery for incision and drainage ([I & D] a minor surgical procedure for skin and soft tissue abscesses) in May 2024, now with wound vac; and on antibiotic therapy doxycycline r/t chronic right hip arthroplasty infection. The care plan interventions included: observation, monitoring, educating, following protocol, assess, evaluation, treatment, and reporting to physician as needed. A review of Resident #2's clinical physician orders reflected: Start date 10/15/24: Daily wet to dry dressing change right knee wound one time a day for wound care [D/C date: 10/25/24] Start date 10/15/24: Do not submerge incision keep wound clean and dry. Perform pin site care daily. Mix 1/2 peroxide, 1/2 Normal Saline and use gauze to clean around pin sites. One time a day for Wound care. Start date 10/15/24: Doxycycline Hyclate Oral Tablet 100 mg. Give 100 mg by mouth two times a day for chronic infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Start date 10/22/24: Mupirocin External Ointment 2%. Apply to right leg wound topically two times a day every Tue, Thu, Sat for right knee wound for 14 administrations. [D/C date: 10/25/24] Start date 10/26/24: Wound care right knee. Cleanse site with wound cleanser. Pat dry, apply black wound vac for dressing. Wound vac at 125 (mm/hg). Change every 3 days and PRN. One time a day every Tue, Thu, Sat. Start date 10/26/24: Mupirocin External Ointment 2%. Apply to right leg wound topically two times a day every Tue, Thu, Sat for right knee wound for 14 administrations. There were no orders noted for weekly head to toe skin assessments. Record review of Resident #2's October 2024 TAR, printed 10/26/24 at 3:59 PM, reflected RN A's user initials for pin site care, wound vac change, and mupirocin applied to right knee wound on Saturday, 10/26/24 that indicated the care was provided in the morning (Qam) as ordered. During an observation and interview on 10/26/24 at 12:02 PM, Resident #2 was sitting upright in chair with legs in a reclined position. The right lower leg had an external fixator (a metal framed medical device mounted on the exterior of the leg with pins inserted through the skin and into the bone of the leg by applying external pressure). There was a clear dressing, dated 10/25/24, on the right outer lateral knee. A suction device and tubing connected the dressing to a tubing attached to a canister a wound vac pump. Resident #2 was awake, alert, and oriented to person, place, time of day, and situation. Resident #2 said wound care was performed yesterday (10/25/24) to clean the pins (external fixator) and the wound vac was placed to the right knee wound. Resident #2 said that she did not know when the dressing would be changed again. Resident #2 said that the pins were supposed to be cleaned daily and the wound vac was supposed to be changed three times a week. During an interview on 10/26/24 at 1:25 PM, RN A said that he worked weekends only from 6AM - 10 PM. RN A was not sure about Resident #2's wound vac dressing change schedule when asked. RN A read the orders out loud, Change every 3 days and as needed. every Tue, Thu, Sat. RN A denied any other wound care needs for Resident #2. When asked what time did [RN A] plan to do the wound vac dressing change, RN A replied, maybe tomorrow. When asked to clarify the order, RN A re-read the order and said, maybe later after dinner. RN A was informed that the investigator wanted to observe (RN A) perform Resident #2's wound care, that included obtaining wound dressing supplies. RN A acknowledged understanding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation of wound care performed by RN A on 10/26/24 at 3:06 PM, there were wound dressing supplies neatly placed on a barrier sheet at the foot of Resident #2's bed, flushed to the right edge. RN A said that he forgot the investigator wanted to observe (RN A) collect wound dressing supplies. RN A performed hand hygiene with soap and water. RN A did not don a clean gown. RN A donned clean gloves and turned off the wound vac. RN A did not clamp the tubing between the canister and the sensor pad. There was no drainage in the tubing noted. RN A pulled at and tugged on the suction device and tubing to remove the dressing from the wound site. Resident #2 grimaced and said that it hurt when RN A pulled on the tubing. Resident #2 informed RN A that she already had pain medicine and to continue with the dressing change. After investigator intervention, RN A lifted the edges of the semi-occlusive dressing and removed the semi-occlusive dressing. The sensor pad (and tubing) and a black foam piece was attached to the. RN A did not discard the old disposable suction device and tubing. RN A placed the disposable suction device and tubing in the windowsill with the semi-occlusive dressing and piece of black foam still attached. RN A said that the DON told him to reuse the sensor pad and tubing because the facility did not have new wound vac supplies. Resident #2's right knee presented a deep red raised wound, approximately one inch (2.54 cm) long and half inch (1.27 cm) wide by visual inspection. RN A did not measure the wound to compare with previous measurements. RN A cleaned the wound with non-sterile gauze soaked with wound cleanser, patted dry with non-sterile gauze, picked up a piece of black foam from the barrier sheet on the bed, and applied to the wound. RN A did not cut the foam to the dimensions of the wound. The black foam covered the wound and overlapped onto the healthy skin around the wound. RN A did not apply barrier cream or skin prep to prevent further breakdown of skin around the wound. RN A placed a piece of adhesive dressing over the foam piece to secure in place. RN A pinched the dressing and cut a small hole. RN A picked up the old suction device and tubing from the windowsill, removed the old adhesive dressing. RN A placed the suction device and tubing over the small hole and secured in place with strips of adhesive dressing. RN A connected the tubing to the tubing attached to the old cannister. RN A turned the wound vac on. RN A told Resident #2 that there was a good seal, and the wound vac was functioning. The dressing did not appear sucked down. During an interview, RN A said that he was checked off a long time ago (greater than two years ago) for wound vac dressing change competency. RN A said a good seal meant there was no air escaping from under the dressing. RN A said reusing the disposable suction pad and tubing increased Resident #2's risk for infection. RN A said that he did not know who was responsible for ordering wound care supplies. RN A said that the DON found some foam pieces in Resident #2's drawer that were not secured in the original sealed package and told him to reuse the suction pad and tubing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/26/24 at 4:09 PM, the DON said that the nurses performed wound care and were responsible for reordering wound care supplies. The DON said that skin assessments were performed weekly and opportunities for staff to discover changes in skin condition were during showers, bed baths, and when incontinent care was performed. The DON said that she totally agreed with the investigator's observation findings. The DON said that she did tell RN A to reuse the disposable wound vac suction pad and tubing. The DON said that she oversaw a NPWT competency checkoff for RN A and needed to locate the documents. The DON said that Resident #2 admitted with orders to apply wet to dry dressings to the right knee. The DON said that the wound doctor gave orders to apply the wound vac. The DON said that the WMD would determine if there the wound improved or worsened. The DON said that it was not common practice to reuse supplies at the facility. The DON said that reusing disposable supplies can increase risk for infection. The DON said that RN A was supposed to don a gown and gloves when he performed wound care as enhanced barrier precautions to prevent cross-contamination. The DON said that head to toe skin checks were performed by the nurses weekly as a skin care approach to help identify skin conditions early. The DON said that she was unsure why Resident #2 did not have a weekly skin assessment 7 days after admission, 10/21/24, or as soon as it was discovered a skin assessment was not done. The DON said that the facility did not have specific policies related to frequency of skin assessments. Interview on 10/26/24 at 4:45 PM, the DON approached the investigator and said that she spoke with the central supply staff and was informed that the wound vac supplies were ordered and stored in the ADON's office. The DON could not explain why she did not inquire with central supply about the wound vac supplies before telling RN A to reuse disposable supplies. Record review of the facility procedure Guide to Negative Pressure Wound Therapy (NPWT), dated January 2024, read in part: General Procedure o Trim the foam sponge to fit the size of the open wound and place it into the wound; the foam should not extend beyond the wound margin. Dressing Changes o Remove the semi-occulsive dressing (a type of wound dressing that allows air to pass through while protecting the wound from liquids) and carefully remove the foam sponge. Risks and Complications Ensure proper placement of sponge and semi-occulsive adhesive cover; avoid sponge contact with healthy skin. Record review of the facility's procedure for Applying Negative Pressure Wound Therapy, Skill 8-11, dated 2011, reflected: Goal: The therapy is accomplished without contaminating the wound area, without causing trauma to the wound, and without causing the patient to experience pain or discomfort. 3. Perform hand hygiene and put on PPE, if indicated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Using sterile technique, prepare a sterile field and add all the sterile supplies needed for the procedure to the field. 11. Put on a gown, mask, and eye protection. 12. Put on clean gloves. Carefully and gently remove the dressing. If there is resistance, use a silicone-based adhesive remover to help remove the drape. 14. Put on sterile gloves. Using sterile technique, irrigate the wound. 17. Wipe intact skin around the wound with a skin-protectant wipe and allow it to dry well. 19. Put on a new pair of sterile gloves, if necessary. Using sterile scissors, cut the foam to the shape and measurement of the wound. Do not cut foam over the wound. More than one piece of foam may be necessary if the first piece is cut too small. Carefully place the foam in the wound. 23. Assess the dressing to ensure seal integrity. The dressing should be collapsed, shrinking to the foam and skin. Record review of Texas Health and Human (HHS) Infection Prevention and Control Measures for Common Infections in LTC Facilities, Version 1.0, 10/07/22, Enhanced Barrier Precautions (p. 14) reflected: Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. Examples of high-contact resident care activities where gown and glove use for enhanced barrier precautions (EBP) are recommended include Wound care: any skin opening requiring a dressing.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46403 Based on interview and record review, the facility failed to ensure that each resident who was incontinent of bladder received appropriate treatment and services for 1 of 2 residents (Resident #1) reviewed for incontinence care. The facility they failed to monitor and document signs and symptoms of bowel movements for Resident#1. This failure could place residents at risk of not having their individual needs met, not receiving necessary care and services, and a decreased quality of life. Findings included: Record review of Resident #1's admission record undated reflected the resident was an [AGE] year-old male, who initially admitted to the facility on [DATE] with a discharge date of [DATE]. Resident#1's diagnoses included hypo-osmolarity and hyponatremia, begin prostatic hyperplasia without lower urinary tract infection, pressure ulcer of sacral region stage, 3, protein calorie malnutrition, Vitamin D deficiency, reduced mobility and need for assistance with personal care. Record review of Resident#1's modified MDS dated [DATE] reflected the Resident #1 refused for toileting hygiene, shower/bathe self and lower body dressing. The MDS reflected Resident #1 was always continent of bladder. Resident#1 had a BIMS score of 07 which indicated serve cognitive impairment. Record review of Resident#1's care plan dated [DATE] reflected: Focus: The resident is incontinent of bladder. Goal: The resident will remain free from skin break down due to incontinence and brief use through the review date and interventions reflected: Brief use: The resident uses disposable briefs. Change per schedule and prn. Clean peri-area with each incontinence episode. Record review of the admission to hospital record dated [DATE] reflected Docusate Sodium 100mg, Colace (stool softener) by mouth every day as needed for constipation. MiraLAX (osmotic laxative - works with water intake in addition to dose) Take 17g by mouth every day. Record review of Resident#1's BM report 15 day look back dated [DATE] to [DATE] reflected no 1st shift (6:00 AM to 2:00 PM) shift documentation of BM movements. On 2nd shift (2:00 PM to 10:00 PM) shift missing documentation on ,d+[DATE], ,d+[DATE], ,d+[DATE],,d+[DATE]/, ,d+[DATE], ,d+[DATE],,d+[DATE]. On 2nd shift no BMs reported on ,d+[DATE], ,d+[DATE], ,d+[DATE],,d+[DATE] and ,d+[DATE]. On 3rd shift (10:00 PM to 6:00 AM) reflected: No BMs on ,d+[DATE],,d+[DATE],,d+[DATE], ,d+[DATE],,d+[DATE] and , d+[DATE]. Record review of Resident #1's July2024, [DATE] and [DATE] MAR reflected: Resident#1 received MiraLAX oral Packet 17 GM (Polyethylene Glycol 3350) Give 1 packet by mouth one time a day for constipation. Review reflected residents received medication every morning. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident#1 Juy 2024, [DATE] and [DATE] TAR reflected: Resident#1 did not receive a dose of Docusate Sodium 100mg, Colace (stool softener) by mouth every day as needed for constipation. Record review of Resident#1 hospital records dated [DATE] at 11:24 PM reflected: a large amount of formed stool throughout the colon and rectum. This guidance are concerned for fecal impaction. ADMIT DIAGNOSIS: SEPSIS with SEPTIC SHOCK FINAL DIAGNOSIS: Fecal impaction. ER arrival vital signs: bp: ,d+[DATE], HR 92. Record review of the WMD notes dated [DATE] reflected ER physician discussed with the family about hospice, and they indicated that they were unable to get hospice at the current facility. Family requested comfort care and hospice. Resident#1 was admitted on [DATE] to inpatient Hospice. Patient gradually declined as expected. Patient passed away peacefully on [DATE]. Interview with POA on [DATE] at 9:15 AM stated the facility killed Resident#1 by not taking good care of his overall health. POA stated every facility that he had been at he was neglected by staff. The POA stated she had the death certificate stated resident died from septic shook that he had for 8 weeks. POA stated she facility doctor, nursing staff are liars and wrote false reports about providing care for Resident#1. The POA stated she did not know Resident#1 had constipation issues and the facility did not keep her informed. Interview on [DATE] at 5:00 AM LVN D stated he remembered the residents but does remember him having constipation concerns or issues. LVN D stated if a resident goes three days without having a bowel movement, he would contact the MD to put the resident on a different medication if needed. Interview on [DATE] at 5:10 AM RN F stated she did not remember Resident#1. RN F stated CNAs report to the charge nurse any constipation issue and then we call the MD to get orders adjusted. Interviews on [DATE] at 5:25 AM with CNA F and CNA G (overnight shift) stated staff did not remember Resident#1. The CNAs stated they did documentation at the end of the shift about bowel movements. The CNAs described the size, form and shape of the BMs on the Plan of Care task sheet. Interviews on [DATE] at 6:05 AM with CAN C, CNA H, CMA I and CNA J stated staff did not remember Resident#1 CNAs stated they do documentation at the end of the shift about bowel movements. CNA'S describe the size, form and shape of the BMs on the Plan of Care task sheet. CNAs stated if a resident did not have a BM in three days on any shift it would be reported to the charge nurse and MD. Interviews on [DATE] with CNA K and CNA L stated staff did not remember Resident#1 stated they do documentation at the end of the shift about bowel movements. CNA'S describe the size, form and shape of the BMs on the Plan of Care task sheet. CNAs stated if a resident did not have a BM and three days it would be reported to the MD by the charge Nurse. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 2:25 PM the ADON stated Resident#1 would refuse medication. ADON stated she does not remember Resident#1 reporting constipation concerns. ADON stated staff worked four days on and two days off. ADON stated CNAs reported in the POC about Bowel movements for all residents. ADON stated if a resident did not have a Bowel Movement in three days it was reported to the charge nurse who notified the MD. ADON stated any change of condition or concerns with residents are reported to the on coming staff and documented in the nurse's notes. ADON stated information about Bowel movements needed to be documented to determine if the Resident needed to be on a different medication. Interview over the phone on [DATE] at 4:30 PM the MD stated he did a head-to-toe assessment on Resident#1 on and he did not see any concerns with constipation at that time. MD stated he checked the resident stomach and there was no tightness and no discomfort reported by the resident at that time. Interview on [DATE] at 6:25 PM the DON and Administrator stated residents' bowel movements were measured by small, medium, and large. The DON revealed softness and firmness was documented on the task list for CNAs to complete. The CNAs were responsible for documenting this information in the POC. DON stated all resident's bowel movements are monitored in the POC and the CNAs know to report to the charge nurse if the resident did not have a BM for three days or more. The Charge nurse would report it to the MD. The MD would put in a different order for the resident. The Administrator stated he expected the nursing staff to document the information correctly so that staff would be alerted about concerns. The Administrator and DON stated the facility did not have a policy for monitoring bowel movement.

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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** 44405 Based on observation, interview, and record review the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, and administering medications for 1 of 3 residents (Resident #3) reviewed for medication administration. RN A failed to administer medications as ordered. RN A informed Resident #3 that he mixed Miralax (brand name of an over-the-counter powder that treats occasional constipation [generic name: Polyethylene glycol (PEG) 3350]) with cranberry juice per Resident #3's request to relieve constipation. Resident #3 did not have an order for Miralax (or generic version). The facility failed to ensure RN A contacted the physician to obtain an order for a medication before administration. This failure placed residents at risk of adverse drug reactions related to drug allergies or not receiving the intended therapeutic benefit of the medication. Findings included: A record review of Resident #3's Admission Record, printed 10/27/24, revealed the resident was a [AGE] year-old female admitted on [DATE] from an acute care facility with a left fibula (calf bone) fracture. Record review on 10/27/24 revealed a Comprehensive MDS Admit Assessment was not initiated. A review of Resident #3's hospital discharge clinical records dated 10/26/24 revealed physician discharge instructions; discharge medications; diet instructions; and to schedule a follow up visit with orthopedic surgeon. Record review did not reveal a baseline care plan. A visual/bedside Kardex report, dated 10/27/24, reflected special instructions for behavior/mood and Lifestyle. There were no interventions or instructions listed. A review of Resident #3's clinical physician orders reflected: Start date 10/27/24 at 6:00 AM: Senokot S Oral Tablet 8.6-50 mg. Give 1 tablet by mouth in the morning for constipation. Hospital discharge medications reflected Senokot S Oral Tablet 8.6-50 mg. Take 1 tablet by mouth two times daily as needed for constipation. Start date 10/26/24 at 9:49 PM: Milk of Magnesia Suspension 7.75%. Give 30cc by mouth every 24 hours as needed for No BM in 3 days. If no results, call MD. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's October 2024 MAR, printed 10/27/24, reflected RN A's user initials on 10/27/24 with a comment code that medications, including over-the-counter medications, were not in administered due to not available or received by pharmacy. During an observation and interview on 10/27/24 at 1:07 PM, CNA C performed incontinent care to Resident #3. Resident #3 said that she was constipated and asked the nurse (RN A) for Miralax. Resident #3 said that RN A administered Miralax mixed in cranberry juice. Resident #3 said it had been a couple of days since her last bowel movement. During an interview on 10/27/24 at 6:10 PM, RN A said that he gave Resident #3 Miralax mixed with cranberry juice and a cup of water to help relieve constipation per her request. When inquired about Resident #3 orders, RN A said that he did not really give Resident #3 Miralax, that he just told her that he did to calm her down. RN A said that Resident #3 was upset because she had not received any medications since admission (10/26/24 around 2:00 PM). RN A could not explain why he did not review Resident #3's orders to see what medications were ordered for constipation as needed. RN A said giving a resident medication that was not ordered could cause harm if allergic to the medication. During an interview on 10/27/24 at 6:30 PM, the DON said that orders must be received from the doctor before any medication was administered. The DON said that it was a collaborative effort between the DON, ADON, and the nurse who entered the orders to ensure the order was correct and that orders were in place for every medication or treatment administered. The DON said that RN A just approached her (10 - 15 minutes prior to interview) and showed her a text to Resident #3's PCP requested an order to administer Resident #3 Miralax. The DON said that the nurse should request and obtain an order before medication was administered to a resident. The DON said a medication not ordered or reviewed by the pharmacy for interactions could be harmful to a resident. The DON said that Resident #3 was upset that she did not receive routine medications that included Alprazolam XR ([Xanax XR] a sedative that can treat anxiety and panic disorder) and oxycodone (a narcotic to treat moderate to severe pain). The DON said that the discharging facility was expected to send a 3-day supply of medications and prescriptions for controlled drugs with a resident admitted to the facility. The DON said that the facility had a locked emergency drug box that contained select medications and controlled drugs as ordered by the physician if medications were not available. The DON said that the nurses should check for availability of medications or call the doctor for alternative medications before telling a resident the medication was not available. The DON said that the facility did not have specific policies related to medication administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44405 Based on observations and interviews, the facility failed to assure that medications were secure and inaccessible to unauthorized staff and residents, for 1 of 3 medication carts (medication cart #1) observed for medication storage. On 10/27/24 at 6:08 PM, RN A failed to ensure medications were secured or attended to by authorized staff when RN A did not lock medication cart #1. On 10/27/24 at 6:08 PM, RN A failed to ensure medications were secured or attended to by authorized staff when RN A left a medication cup with two pills and a resident's medication blister pack with pills on top of the medication cart unattended. These failures place residents at risk of a potential for more than minimal harm if a resident accessed and ingested medications or drug diversion. Findings included: In an observation on 10/27/24 at 6:08 PM revealed medication cart #1 in Tower A unattended and not under direct observation of authorized staff. The lock was in the out position and the drawers were able to be opened and left the medications accessible. Residents' routine and PRN medication blister packs and OTC medications were organized in drawers of the medication cart. At 6:10 PM, RN A returned to the medication cart. During an observation and interview on 10/27/24 at 6:10 PM, RN A approached the medication cart where the investigator was standing and said that he was down the hall getting medications from LVN B's cart that were not available on his cart. RN A reached down and pushed the cart lock into the locked position. The click was heard when the cart locked. RN A said that he did not have a specific nurse cart. RN A said that he placed residents at risk of taking medications that may be allergic to or someone could steal medications because the cart was not locked. During an interview on 10/27/24 at 6:30 PM, the DON said that it was unacceptable to leave medication carts unlocked and unattended or not within direct line of site and arms reach for resident safety and to prevent drug diversion. The DON said that it nurses were responsible for securing medications whenever they were away from the medication cart. The DON said if residents could access the medications, swallow a medication that they are allergic to, or have an adverse reaction. The DON said she would hold a one-to-one verbal session with RN A about medication storage and drug diversion to prevent reoccurrence. The DON stated surveillance of locked medication carts are conducted regularly for quality assurance. The DON said that that facility did not have a specific policy related to Medication Storage - Storage of Medication.

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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** 46403 Based on observation, interview, and record review, 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 infectious diseases and infections 1 of 5 residents (Resident #2) reviewed for infection control, in that: 1. RN A failed to follow facility protocol and don a gown in addition to gloves to reduce the risk of transmission of bloodborne pathogens and apply enhanced barrier precautions (EBP) when he performed wound vac dressing change to Resident #2's right knee on 10/26/24. 2. RN A re-used the wound vac disposable components (suction device and tubing) when he performed wound vac dressing change to Resident #2's right knee on 10/26/24. These failures placed residents with wounds at an increased risk of infection, wound contamination, unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and failure of the wound to heal. Findings included: A record review of Resident #2's Admission Record printed 10/26/24 revealed the resident was a [AGE] year-old female admitted on [DATE]. Resident #2 had diagnoses of unspecified fracture of lower end of right tibia; unspecified open wound, Right knee, Sequela (a condition that results from a previous illness, injury, or medical intervention); and Infection and Inflammatory reaction due to internal right hip prosthesis, subsequent encounter (routine care during the healing or recovery phase after active treatment was received for a condition). The Admission Record reflected 13 days length of stay. A record review of the Comprehensive MDS Admit assessment dated [DATE] reflected Resident #2's BIMS score was 15, which indicated intact cognitive response. The Comprehensive MDS Admit Assessment reflected Resident #2 needed partial assistance from another person to complete ADLs. Section M - Skin conditions revealed Resident #1 was not at risk for developing pressure ulcers/injuries and surgical wound(s) were present on admission. A review of Resident #2's hospital discharge clinical records dated 10/11/24 revealed final discharge instructions that included discharge medications; diet type; Activity: Non-weightbearing to right leg; Wound/Dressing Care: do not submerge incision. Keep wound clean and dry. Perform pin site care daily. Mix 1/2 Peroxide and 1/2 Normal Saline and use gauze to clean around pin sites; Follow up with PCP in 1 week after discharge (from hospital); Follow up in 2 - 3 weeks with orthopedic surgeon; Follow up in 1 - 2 weeks with right ankle orthopedic surgeon; and Daily wet to dry dressing change right knee wound. Record review revealed a skin check on admission (10/14/24). There were no other skin checks, or a weekly skin assessment performed on Resident #2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2 progress notes dated 10/14/24 at 7:34 PM, revealed right lateral knee trauma wound 1.2 cm x 1 cm x 0.1 cm (LxWxD) 90% granulation with moderated serosanguinous drainage. Record review of Resident #2's care plan, initiated 10/16/24, reflected [Resident #2] had an alteration in musculoskeletal status r/t fracture of the right tibia and fibula, external fixator placed 10/09/24; had a chronic infection of the right hip after hip surgery; had actual impairment to skin integrity of the right knee - infection with previous surgery for incision and drainage ([I & D] a minor surgical procedure for skin and soft tissue abscesses) in May 2024, now with wound vac; and on antibiotic therapy doxycycline r/t chronic right hip arthroplasty infection. The care plan interventions included: observation, monitoring, educating, following protocol, assess, evaluation, treatment, and reporting to physician as needed. A review of Resident #2's clinical physician orders reflected: Start date 10/15/24: Daily wet to dry dressing change right knee wound one time a day for wound care [D/C date: 10/25/24] Start date 10/15/24: Do not submerge incision keep wound clean and dry. Perform pin site care daily. Mix 1/2 peroxide, 1/2 Normal Saline and use gauze to clean around pin sites. One time a day for Wound care. Start date 10/15/24: Doxycycline Hyclate Oral Tablet 100 mg. Give 100 mg by mouth two times a day for chronic infection. Start date 10/22/24: Mupirocin External Ointment 2%. Apply to right leg wound topically two times a day every Tue, Thu, Sat for right knee wound for 14 administrations. [D/C date: 10/25/24] Start date 10/26/24: Wound care right knee. Cleanse site with wound cleanser. Pat dry, apply black wound vac for dressing. Wound vac at 125 (mm/hg). Change every 3 days and PRN. One time a day every Tue, Thu, Sat. Start date 10/26/24: Mupirocin External Ointment 2%. Apply to right leg wound topically two times a day every Tue, Thu, Sat for right knee wound for 14 administrations. There were no orders noted for weekly head to toe skin assessments. Record review of Resident #2's October 2024 TAR, printed 10/26/24 at 3:59 PM, reflected RN A's user initials for pin site care, wound vac change, and mupirocin applied to right knee wound on Saturday, 10/26/24 that indicated the care was provided in the morning (Qam) as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/26/24 at 12:02 PM, Resident #2 was sitting upright in chair with legs in a reclined position. The right lower leg had an external fixator (a metal framed medical device mounted on the exterior of the leg with pins inserted through the skin and into the bone of the leg by applying external pressure). There was a clear dressing, dated 10/25/24, on the right outer lateral knee. A suction device and tubing connected the dressing to a tubing attached to a canister a wound vac pump. Resident #2 was awake, alert, and oriented to person, place, time of day, and situation. Resident #2 said wound care was performed yesterday (10/25/24) to clean the pins (external fixator) and the wound vac was placed to the right knee wound. Resident #2 said that she did not know when the dressing would be changed again. Resident #2 said that the pins were supposed to be cleaned daily and the wound vac was supposed to be changed three times a week. During an interview on 10/26/24 at 1:25 PM, RN A said that he worked weekends only from 6AM - 10 PM. RN A was not sure about Resident #2's wound vac dressing change schedule when asked. RN A read the orders out loud, Change every 3 days and as needed. every Tue, Thu, Sat. RN A denied any other wound care needs for Resident #2. When asked what time did [RN A] plan to do the wound vac dressing change, RN A replied, maybe tomorrow. When asked to clarify the order, RN A re-read the order and said, maybe later after dinner. RN A was informed that the investigator wanted to observe (RN A) perform Resident #2's wound care, that included obtaining wound dressing supplies. RN A acknowledged understanding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation of wound care performed by RN A on 10/26/24 at 3:06 PM, there were wound dressing supplies neatly placed on a barrier sheet at the foot of Resident #2's bed, flushed to the right edge. RN A said that he forgot the investigator wanted to observe (RN A) collect wound dressing supplies. RN A performed hand hygiene with soap and water. RN A did not don a clean gown. RN A donned clean gloves and turned off the wound vac. RN A did not clamp the tubing between the canister and the sensor pad. There was no drainage in the tubing noted. RN A pulled at and tugged on the suction device and tubing to remove the dressing from the wound site. Resident #2 grimaced and said that it hurt when RN A pulled on the tubing. Resident #2 informed RN A that she already had pain medicine and to continue with the dressing change. After investigator intervention, RN A lifted the edges of the semi-occlusive dressing and removed the semi-occlusive dressing. The sensor pad (and tubing) and a black foam piece was attached to the. RN A did not discard the old disposable suction device and tubing. RN A placed the disposable suction device and tubing in the windowsill with the semi-occlusive dressing and piece of black foam still attached. RN A said that the DON told him to reuse the sensor pad and tubing because the facility did not have new wound vac supplies. Resident #2's right knee presented a deep red raised wound, approximately one inch (2.54 cm) long and half inch (1.27 cm) wide by visual inspection. RN A did not measure the wound to compare with previous measurements. RN A cleaned the wound with non-sterile gauze soaked with wound cleanser, patted dry with non-sterile gauze, picked up a piece of black foam from the barrier sheet on the bed, and applied to the wound. RN A did not cut the foam to the dimensions of the wound. The black foam covered the wound and overlapped onto the healthy skin around the wound. RN A did not apply barrier cream or skin prep to prevent further breakdown of skin around the wound. RN A placed a piece of adhesive dressing over the foam piece to secure in place. RN A pinched the dressing and cut a small hole. RN A picked up the old suction device and tubing from the windowsill, removed the old adhesive dressing. RN A placed the suction device and tubing over the small hole and secured in place with strips of adhesive dressing. RN A connected the tubing to the tubing attached to the old cannister. RN A turned the wound vac on. RN A told Resident #2 that there was a good seal, and the wound vac was functioning. The dressing did not appear sucked down. During an interview, RN A said that he was checked off a long time ago (greater than two years ago) for wound vac dressing change competency. RN A said a good seal meant there was no air escaping from under the dressing. RN A said reusing the disposable suction pad and tubing increased Resident #2's risk for infection. RN A said that he did not know who was responsible for ordering wound care supplies. RN A said that the DON found some foam pieces in Resident #2's drawer that were not secured in the original sealed package and told him to reuse the suction pad and tubing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/26/24 at 4:09 PM, the DON said that the nurses performed wound care and were responsible for reordering wound care supplies. The DON said that skin assessments were performed weekly and opportunities for staff to discover changes in skin condition were during showers, bed baths, and when incontinent care was performed. The DON said that she totally agreed with the investigator's observation findings. The DON said that she did tell RN A to reuse the disposable wound vac suction pad and tubing. The DON said that she oversaw a NPWT competency checkoff for RN A and needed to locate the documents. The DON said that Resident #2 admitted with orders to apply wet to dry dressings to the right knee. The DON said that the wound doctor gave orders to apply the wound vac. The DON said that the WMD would determine if there the wound improved or worsened. The DON said that it was not common practice to reuse supplies at the facility. The DON said that reusing disposable supplies can increase risk for infection. The DON said that RN A was supposed to don a gown and gloves when he performed wound care as enhanced barrier precautions to prevent cross-contamination. The DON said that head to toe skin checks were performed by the nurses weekly as a skin care approach to help identify skin conditions early. The DON said that she was unsure why Resident #2 did not have a weekly skin assessment 7 days after admission, 10/21/24, or as soon as it was discovered a skin assessment was not done. The DON said that the facility did not have specific policies related to frequency of skin assessments. Interview on 10/26/24 at 4:45 PM, the DON approached the investigator and said that she spoke with the central supply staff and was informed that the wound vac supplies were ordered and stored in the ADON's office. The DON could not explain why she did not inquire with central supply about the wound vac supplies before telling RN A to reuse disposable supplies. Record review of the facility procedure Guide to Negative Pressure Wound Therapy (NPWT), dated January 2024, read in part: General Procedure o Trim the foam sponge to fit the size of the open wound and place it into the wound; the foam should not extend beyond the wound margin. Dressing Changes o Remove the semi-occulsive dressing (a type of wound dressing that allows air to pass through while protecting the wound from liquids) and carefully remove the foam sponge. Risks and Complications Ensure proper placement of sponge and semi-occulsive adhesive cover; avoid sponge contact with healthy skin. Record review of the facility's procedure for Applying Negative Pressure Wound Therapy, Skill 8-11, dated 2011, reflected: Goal: The therapy is accomplished without contaminating the wound area, without causing trauma to the wound, and without causing the patient to experience pain or discomfort. 3. Perform hand hygiene and put on PPE, if indicated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Using sterile technique, prepare a sterile field and add all the sterile supplies needed for the procedure to the field. 11. Put on a gown, mask, and eye protection. 12. Put on clean gloves. Carefully and gently remove the dressing. If there is resistance, use a silicone-based adhesive remover to help remove the drape. 14. Put on sterile gloves. Using sterile technique, irrigate the wound. 17. Wipe intact skin around the wound with a skin-protectant wipe and allow it to dry well. 19. Put on a new pair of sterile gloves, if necessary. Using sterile scissors, cut the foam to the shape and measurement of the wound. Do not cut foam over the wound. More than one piece of foam may be necessary if the first piece is cut too small. Carefully place the foam in the wound. 23. Assess the dressing to ensure seal integrity. The dressing should be collapsed, shrinking to the foam and skin. Record review of Texas Health and Human (HHS) Infection Prevention and Control Measures for Common Infections in LTC Facilities, Version 1.0, 10/07/22, Enhanced Barrier Precautions (p. 14) reflected: Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. Examples of high-contact resident care activities where gown and glove use for enhanced barrier precautions (EBP) are recommended include Wound care: any skin opening requiring a dressing.