STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676332	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Bay Area	4900 East Sam Houston Parkway South Pasadena, TX 77505

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on interviews and record review, the facility failed to ensure residents had the right to be free from any physical or chemical restraints imposed for the purpose of discipline or convenience for one (Resident #1) of five residents reviewed for chemical restraints. 1. The DON changed the medication order from Seroquel Oral Tab 100 MG to be administered at bedtime to be administered in the morning. Resident #1 slept all day until 7-8pm for 3 days. 2. The DON failed to attain verbal consent from a physician or Resident #1, who was her own responsible party. This failure could place 21 residents who receive medications at the facility at risk for adverse medication effects and potential harm. Findings included: Record review of Resident#1's face sheet dated 03/28/24 revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were bipolar disorder (extreme mood swings), multiple sclerosis (immune system attacking the brain and spinal cord-central nervous system), insomnia (cannot sleep), anemia, obesity, lymphedema (swelling due to build up of lymph fluid), and mood disorder with depressive features. Record review of Resident #1's MDS assessment dated [DATE] revealed a BIMS Summary Score of 15 indicating her cognition was intact. The functional limitation in range of motion revealed impairment on both sides of lower extremity. She required substantial/maximal assistance for toileting hygiene, personal hygiene, and she required partial/moderate assistance for lower body dressing. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan, last review dated 10/18/23 revealed she was at risk for adverse reactions related to polypharmacy. Interventions and tasks included to: a. discuss with resident and family the number and type of medications resident was taking and the potential for drug interactions and side effects for over medication, b. monitor for possible signs and symptoms of adverse drug reactions (fatigue, lethargy, confusion, poor appetite .), c. request physician to review and evaluate medications, and d. review pharmacy consult recommendations, and follow up as needed. The care plan stated Resident #1 used psychotropic medications such as Seroquel, related to bipolar disorder and depression. Intervention and tasks included a. to administer psychotropic medications as ordered by a physician at bedtime. Monitor for side effects and effectiveness q-shift, b. consult with pharmacy, MD to consider dosage reduction when clinically appropriate, c. monitor and report PRN any adverse reactions to psychotropic medications (fatigue, loss of appetite .). Record review of Resident #1's Psychiatric Subsequent assessment dated [DATE] documented that Resident #1 denied symptoms of sad moods, fatigue, loss of appetite, excessive worry/ restlessness, hallucinations, and symptoms of delayed sleep symptoms. It stated that per staff patient continued to refuse to leave room, patient is receptive with care, pleasant with most staff, and no recent behavioral changes. Her mental status was described as oriented to person, place, day, month, and year, her mood was neutral, and her thought process was logical linear. Her current medications were Eskalith (used to treat bipolar disease) 2 300 mg capsules QHS, temazepam 2 15 mg capsules QHS, sertraline 1 50 mg tablet daily, and Seroquel 1 100 mg tablet QHS to treat bipolar disorder. Record review of Resident #1's MAR (medication administration record) revealed that she was ordered to take 1 100 MG tablet of Seroquel by mouth at bedtime related to bipolar disorder. This order was started on 09/13/23 at 2100 (9pm) and discontinued on 03/12/24 at 1006 (10:06 am). On 03/13/24 at 0900 (09:00 am), a new order of 100 MG tablet of Seroquel was ordered to be given by mouth one time a day but was discontinued on 03/16/24 at 1205 (12:05 pm). On 03/16/24 at 2100 (9pm), the order for 1 100 MG tablet of Seroquel was changed back to be given at bedtime. Record review of an Order Audit Report for Resident #1 dated 03/12/24 revealed that the DON changed the order for Seroquel Oral Tablet 100 MG administration from bedtime to the daytime. Record review of an Order Audit Report for Resident #1 dated 03/16/24 revealed that the DON changed the order for Seroquel Oral Tablet 100 MG administration from daytime back to its original bedtime order. Record review of Resident #1's weights and vital from 03/13/24- 03/16/24 did not reveal any changes or adverse reactions. Record review of Resident #1's progress notes showed no notes related to changes in behaviors. -On 03/16/24 at 04:18 pm, LVN A documented the Resident #1 inquired about order for Seroquel Oral Tablet 100 MG being changed from original order that was scheduled during 11pm now changed to 9am. There was no previous documentation regarding medication scheduled change. The medication schedule was changed on 3/12/24 at 9am by the DON. Resident #1 was very angry because she never requested medication change and stated that she was never informed or consented to the change. The DON and Administrator were made aware. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/16/24 at 12:08 pm, the DON documented that the patient was informed of medication time change. Patient was own RP. Original order to be reinstated per resident request. MD notified and was in agreement with change. Record review of the DON's employee file revealed that on 03/27/24, she was involuntarily terminated due to job performance. In an interview on 03/28/24 at 11:19 am, Resident #1 stated that things have been horrible at the facility since the last state visit. She explained that she was bipolar and was prescribed pills for major depression. For a few days, she stated that she was sleeping until 7-8 pm at night. After a few days, she realized that her night dose of Seroquel had been switched so that she would receive it in the daytime. She said this started on 03/13/24 and she found out that it was switched by the DON on 03/16/24. This medication made her sleepy and that explained why she was sleeping throughout the day. She brought her concerns to the weekend LVN when she noticed her giving her the Seroquel medication in the daytime. The weekend nurse looked into Resident #1's concerns and confirmed to Resident #1 that the DON had switched her medication administration time without her consent although Resident #1 was her own responsible party. In an interview on 03/28/24 at 03:26 pm with CNA A, she stated that she had worked at the facility for three years as a medication tech until the facility did staffing adjustments and pulled her to the floor to be a CNA. She explained that nurses had the ability to change orders, but they must receive a verbal or written order from the physician to change it. She described Seroquel as a tranquilizer for behaviors and anxiety, dependent on the resident. CNA A stated that a side effect that she had witnessed from Seroquel was sleepiness. She also recounted that in her time of working as a medication aid for the facility, Resident #1 had always received her Seroquel medication at bedtime. In an interview on 03/28/24 at 03:33 pm with the Admin, she stated that when LVN A called her regarding Resident #1's medication order, she called the DON and asked her why it had been changed. The DON stated that she called Dr. T and he said that it was ok to do so. The Admin explained that with the resident being cognitive, she was not allowed to change it. She stated that to her knowledge, Dr. T did not tell her she could change the order and she felt that she was causing all types of trouble. In an interview on 03/28/24 at 04:49 pm with Dr. T, he said that when he spoke with the DON regarding Resident #1's Seroquel order, the DON made it seem like the order request came from the resident. Resident #1 had resided at the facility for a long time, and he could not remember if he authorized anything for this change. He stated that to make adjustments to orders, there has to be some sort of issue or behaviors. He described Resident #1 as pretty simple and noted that he saw her once a month. He could not recall having any issues with her that would cause him to come in to check on her or want to change the order. If he did have a reason, he would give the order change verbally, but the nurse would document that he was called and gave permission to change the order. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/29/24 at 10:14 am with the DON, she stated that as a result of the last investigation completed with the state (exit date 03/12/24), she had been terminated, and was no longer a part of the facility. She explained that the reason that she was terminated was because of Resident #1 and Resident #2 (will be introduced in additional tags) and she expressed the behaviors noted were not her. When asked about the medication order of Seroquel being switched, she stated that Resident #1 was having lots of behaviors but as a result of the last survey I was terminated, and I do not have a response. Thank you. She ended the call. In an interview on 03/29/24 at 10:20 am with LVN A, she stated that she normally did skin assessments and wound care, but she worked as a medication aid about a week ago. Resident #1 was described as alert and oriented x4 (cognitively intact) and knew all of her medications. When she arrived to her room to provide wound care and administer her medication, Resident #1 stated Oh my god you're here, I need to tell you something. Resident #1 told LVN that she had been feeling really sleepy throughout the day and she believed her medication was wrong or different. Resident #1 was her own power of attorney and she requested that LVN check medications placed in her cup and she informed the resident that her Seroquel order had been changed from bedtime administration to the day time. LVN stated that she sent a text message to the DON and told her Resident #1 had requested to know why the order had been changed because no one informed her, nor did they ask. The DON responded to the LVN that she thought the change in the order would be better for her. After that conversation, she called the Admin and let her know what was going on and she also gave Resident #1 the Admin's phone number. The DON changed the order back to 1 tablet 100 MG Seroquel QHS and the LVN documented this in the progress notes. She explained that in the past 8 months that she had worked at the facility, she had never known the resident to have any behaviors, and if she did, it must be documented in her progress notes. Resident #1 only wanted to sit in her room and would only use her call light if she needed pain medication or needed to be changed. The doctor was could not remember Resident #1's complete medication list and did not note any adverse reactions. In an interview on 03/29/24 at 10:40 am, Med Aide A stated that he no longer worked at the facility as of March 15th, but he had worked with Resident #1 often. He described her as a good person and said that she was always very chill but would be vocal if she needed something. He was not aware of the medication order change; he just administered them as he saw listed on the MAR. In an interview on 03/29/24 at 11:52pm with the Admin, she stated that the risk of falsifying records could put the resident at harm. If staff did not follow physician orders, there could be behaviors with Resident #1's medication or she could be at risk for medication interactions. After the incident with Resident #1, Admin requested a psychiatric referral and they should be coming to the facility soon. Record review of the facility's Medication and Treatment Policy revised July 2016 revealed that: 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 2. Only authorized licensed practitioners or individuals authorized to take verbal orders from practitioners shall be allowed to write orders in the medical record. 3. Drugs and biological orders must be recorded on the physician's orders sheet and the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. 5. The signing of orders shall be by signature or a personal computer key. Signature stamps may not be used. 6. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescribers last name, credentials, and the date and time of the order. 7. Verbal orders must be signed by the prescriber and his or her next visit. Record review of the facility's Coordinating/Implementing Abuse, Neglect, and Exploitation Policies and Procedures revised April 2021, revealed that the administrator is responsible for the overall coordination and implementation of our facilities policies and procedures against abuse, neglect, exploitation, and misappropriation of resident property.

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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** 46561 Based on interviews and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for two (Resident #1 and Resident #2) of five residents reviewed for quality of care. 1. The DON falsified documentation that wound care was given to Resident #1 on 03/15/24 and 03/18/24. 2. LVN B failed to provide wound care services to Resident #2 everyday per physician orders. These failures could place 2 residents who receive wound care at risk for infections, healing regression, and pain. Findings included: 1.Resident #1 Record review of Resident#1's face sheet dated 03/28/24 revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were bipolar disorder (extreme mood swings), multiple sclerosis (immune system attacking the brain and spinal cord-central nervous system), insomnia (cannot sleep), anemia, obesity, lymphedema (swelling due to build up of lymph fluid), and mood disorder with depressive features. Record review of Resident #1's care plan, last review dated 10/18/23 revealed she had bladder/bowel incontinence r/t impaired mobility and MS. Interventions were Clean peri-area with each incontinence episode, incontinent: check the resident every 2 hours and as required for incontinence care and PRN. Resident #1 has Multiple sclerosis and interventions/tasks were Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments .Monitor/document/report to MD PRN: S/SX of damage to motor and sensory control centers: urinary frequency, urgency or retention, urinary or fecal incontinence, constipation. She had an ADL Self Care performance deficit r/t MS, limited mobility with interventions to praise all efforts at self-care, transfer. Resident required extensive assist x 1 staff participation to reposition and turn in bed, encouraged to participate to the fullest extent possible with each interaction. For personal hygiene/oral care, the Resident #1 required an extensive assist x1 staff participation with personal hygiene and oral care. Record review of Resident #1's annual MDS assessment dated [DATE] revealed a BIMS Summary Score of 15 indicating her cognition was intact. The functional limitation in range of motion revealed impairment on both sides of lower extremity. She required substantial/maximal assistance for toileting hygiene, personal hygiene, and she required partial/moderate assistance for lower body dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Clinical Orders reflected that a wound care order on the big toe had begun on 02/17/24. Orders stated to clean wound on right big toe with wound cleanser, pat dry, apply TBA Ointment, cover with dry dressing every day until healed. Once healed start on Clotrimazol solution for nail fungal infection. DC this order when wound care from ingrown toenail heals. One time a day for Wound healing. Resident #2 also had an order to complete the Braden scale weekly assessment started 11/13/23. Record review of Resident #1's WAR (wound administration record) revealed that on 03/15/24 the DON signed off that she performed wound care for the resident. On 03/18/24, the DON signed off that she completed wound care, and that she completed the Braden skin weekly Assessment. Record review of the DON's employee file revealed that on 03/27/24, she was involuntarily terminated due to job performance. In an interview on 03/28/24 at 11:19 am, Resident #1 stated that she had a wound on one of her toes and it was bandaged. She stated that the DON would lie and say that she provided wound care, and it would display that on the computer. She stated the DON was not allowed in her room and expressed so how was she going to take care of it. She described the DON as a bully ass lady and believed that staff were afraid to talk about it. Resident #2 stated to check 03/15/24 and 03/18/24 or 03/19/24 and it would reflect that the DON signed off on care because she was the nurse on the floor. In an interview on 03/29/24 at 11:52pm with the Admin, she stated that the risk of falsifying records could put the resident at harm. If staff do not follow physician orders, there could be behaviors with Resident #1's medication or she could be at risk for medication interactions. She stated that the DON was not allowed in Resident #1's room so there was no way she could have completed wound care. She explained that the facility made the right decision with terminating her employment. 2.Resident #2 Record review of Resident #2's facesheet revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were type 2 diabetes (affects your body's ability to use insulin and causes high blood sugar levels), heart failure, morbid (severe) obesity, chronic kidney disease, and peripheral vascular disease (a condition that narrows the arteries and reduces blood flow to the arms or legs). Record review of Resident #1's comprehensive MDS assessment dated [DATE] reflected a BIMS score a 05, moderately impaired. Record review of Resident #2's care plan showed that there was not a completed care plan as of 03/29/24. Record review of Resident #2's Clinical orders revealed that she had 3 wound care orders. a. (revised 01/24/24) ordered non-surgical cleansing or right lower leg. Wound spray-collagen -ABD pad-kerlix/ coban (elastic bandage wrap) daily. b. (revised 01/24/24) ordered mid abdomen- nonsurgical cleansing/ wound spray- collagen- pat dry apply-mupirocin ointment. Cover with dry sterile dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. (revised 01/22/24) ordered non-surgical cleansing to wound bed then cover with xeroform then cover with dry dressing. Clean wound to left calf with NS (normal-saline), apply collagen powder and xeroform to wound base, cover with ABD pad and wrap with kerlix dressing and ace bandage every day and as needed. Record review of Resident #2's WAR (wound administration record) for March 2024 reflected that Resident #2 did not receive wound care services for her three wounds on 03/12/24, 03/20/24, 03/21/24, 03/22/24, and 03/27/24. Record review of Resident #2's progress notes from 03/04/24 through 03/29/24 did not display any notes that indicated why the resident did not receive wound care on dates 03/12/24, 03/20/24, 03/21/24, 03/22/24, and 03/27/24. Progress note written by CNA B on 01/22/24 displayed: Note Text: Resident AOx4 (alert and oriented, cognitively intact), stable and able to make her needs known. Resident stating that she is to receive wound care treatment daily to the left leg and abdomen. She stated that the last wound treatment she received was on Wednesday 1/17/24 by wound care physician. There were no wound care orders on PCC (online resident portal) for resident. ADON (ex- employee) notified via text message regarding this matter. She replied that she would follow up on matter tomorrow 1/22/24. Record review of the March 2024 Staff Schedule reflected that LVN B was the floor nurse on 03/12/24, 03/20/24, 03/21/24, 03/22/24, and 03/27/24. In an interview on 03/28/24 at 12:03 pm with Resident #2, she stated that she had a wound on her leg and an outside lady from another place came in once a week to perform wound care. She recalled that the last time her wound was changed was on Tuesday and it was supposed to be changed every day, although they do not change it like they were supposed to. She stated that on 03/25/24, an aid was changing her, and they could smell an odor coming off of the wound. She described the wound as smelly. In an interview on 03/28/24 at 01:06 pm with LVN B, she expressed that she was the nurse and her duties included wound care and as of 03/25/24, medication passes. She felt that this change made it difficult for her to complete her daily tasks and that it put too much on her. She stated that management explained the reason her duties were expanded was due to the census being low (currently 21). LVN B was asked about the wound care orders for Resident #2 and she logged into PCC to review. She stated that as of 01/24/24, Resident #2 was supposed to receive wound care every day. She asked, how am I going to do that every day? and stated that she would be working until 03/30/24. LVN B stated that nurses were supposed to do wound care on Wednesday's, even if the wound care company came in. She was told that the nurses still needed to try but stated that sometimes it didn't get done. She stated that if she did not complete her tasks, she should notify the DON but she was unsure if she was still employed at the facility. When asked when the last time she treated the wound, she said that she would have to check the WAR but she knew it was done over the weekend by LVN A. In an interview on 03/28/24 at 04:43 pm with the Admin, she stated that wound care came to the facility every Wednesday and they were there on 03/27/24. The wound care company progress notes were requested, and they were sent that evening after 5pm. Record review of the wound care company's provider notes reflected that on wound care was provided to Resident #2 every Wednesday. Wound description listed the following measurements on service dates: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/31/2024-4.5x4.8x0.2 2/7/2024-6.0x4.8x0.1 2/14/2024-6.0x4.8x0.1 2/21/2024- 5.8x4.6x0.2 2/28/2024-5.6x4.5x0.2 3/6/2024-5.6x4.5x0.2 Dates of services in March were 03/06/24, 03/13/24, 03/20/24, and 03/26/24. Progress note on 03/13/24 noted that the wound on the left posterior lower leg had a distressing pain level of 4, no odor, and heavy exudate (fluid that leaks out of blood vessels into nearby tissues). Progress note on 03/20/24 noted that the wound on the left posterior lower leg had a distressing pain level of 4, mild odor, and heavy exudate. Review of wound care note on 03/26/24 measured the wound at 5.2x4.2x0.3 cm and was without odor with moderate exudate. Each progress note documented that the wound had a poor wound progression due to immobility, comorbidities, and age determinants. In an interview on 03/29/24 at 11:52 am with the Admin, she stated that the duties of nurses were expanded to include medication administration on top of normal duties, but the facility had a census of 21 and they had not received any new admissions or doctor's since she had been hired on 03/03/24. She explained that the facility was fully staffed and pulled up the staffing schedule per shift which included two aides who worked with 11 residents a piece and 1 nurse. She stated that she asked LVN A to come in today to assist LVN B so that she could assure all of her tasks were completed. Admin further explained that each nurse worked a 12 hour shift (6am- 6pm) and that completion of daily tasks boiled down to time management. She stated that if she did not have time to complete wound care, she should have let the DON, who oversees nursing staff, and the night shift nurse know so that it could be completed. Admin explained that not following physician orders could lead to harm and if there was a problem, the facility could miss it, and the problem could be caught too late. Record review of the facility's Charting and Documentation Policy revised July 2017, revealed that documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The following information is to be documented in the resident medical record: a. Objective observations b. Medications administered c. Treatments or services performed d. Changes in the resident's condition e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives.

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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** 46561 Based on observations, interviews, and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for one (Resident #2) of two residents reviewed for wound care. Licensed Vocational Nurse (LVN B) failed to properly wash or sanitize her hands in between glove changes when providing wound care to Resident #2. This deficient practice could place 2 residents who received wound care at risk for cross contamination and/or spread of infection. Findings included: Record review of Resident #2's facesheet revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were type 2 diabetes (affects your body's ability to use insulin and causes high blood sugar levels), heart failure, morbid (severe) obesity, chronic kidney disease, and peripheral vascular disease (a condition that narrows the arteries and reduces blood flow to the arms or legs). Record review of Resident #1's annual MDS assessment dated [DATE] reflected a BIMS score a 05, moderately impaired. Record review of Resident #2's care plan showed that there was not a completed care plan as of 03/29/24. Record review of Resident #2's Clinical orders revealed that she had 3 wound care orders. a. (revised 01/24/24) ordered non-surgical cleansing or right lower leg. Wound spray-collagen -ABD pad-kerlix/ coban (elastic bandage wrap) daily. b. (revised 01/24/24) ordered mid abdomen- nonsurgical cleansing/ wound spray- collagen- pat dry apply-mupirocin ointment. Cover with dry sterile dressing. c. (revised 01/22/24) ordered non-surgical cleansing to wound bed then cover with xeroform then cover with dry dressing. Clean wound to left calf with NS (normal-saline), apply collagen powder and xeroform to wound base, cover with ABD pad and wrap with kerlix dressing and ace bandage every day and as needed. Record review of Resident #2's WAR (wound administration record) for March 2024 reflected that Resident #2 did not receive wound care services for her three wounds on 03/12/24, 03/20/24, 03/21/24, 03/22/24, and 03/27/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676332	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Bay Area	4900 East Sam Houston Parkway South Pasadena, TX 77505

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/28/24 at 01:06 pm with LVN B, she expressed that she was the nurse and her duties included wound care and as of 03/25/24, medication passes. She felt that this change made it difficult for her to complete her daily tasks and that it put too much on her. She stated that management explained the reason her duties were expanded were due to the census being low (currently 21). LVN B was asked about the wound care orders for Resident #2 and she logged into PCC to review. She stated that as of 01/24/24, Resident #2 was supposed to receive wound care every day. In an observation on 03/28/24 at 03:38 pm, Wound care was observed for Resident #2 by LVN B. On the lower posterior of the left leg, LVN B grabbed the supplies and placed a bag in the trash can. She washed her hands and put on gloves. She grabbed the bedside table and pushed it to the side, raised the resident's bed, and took Resident #2's leg off her pillows. LVN B left the room and returned with more supplies and placed it on a bed pad on top of the bedside table. LVN B removed the bandages, and a lot of drainage was noted on the dressing. The drainage was brown and yellow and looked like pus. There was also bright red blood and LVN B explained that the wound was sloughing off. LVN B used gauze and patted the wound with saline cleanser. She removed her gloves and stated that she needed hand sanitizer, and she did not have any. She removed the current gloves on her hands and put on new gloves without sanitizing. She then took two ABD pads and placed a yellow xeroform healing pad and placed them on Resident #2's leg, then added collagen powder, and calcium alginate dressing. She continued to wrap the wound, removed her gloves, then washed her hands at the sink. After wound care, LVN B was asked why she did not have any hand sanitizer and where was it. LVN B smiled really big and looked at the state investigator. No comment was made or given on what this failure could cause. In an interview on 03/29/24 at 11:52 am with the Admin, she stated that the duties of nurses were expanded to include medication administration on top of normal duties. The facility had a census of 21 and they had not received any new admissions or doctor orders since she had been hired on 03/03/24. She explained that the facility was fully staffed and pulled up the staffing schedule per shift which included two aides who worked with 11 residents a piece and 1 nurse. She stated that she asked LVN A to come in today to assist LVN B so that she could assure all of her tasks were completed. When asked about if hands should be sanitized in between glove changes, the Admin responded yes. She stated that if you did not practice proper infection control during wound care, a resident could get an unknown organism like MRSA (Methicillin-resistant Staphylococcus aureus infection is caused by a type of staph bacteria that's become resistant to many antibiotics) and the LVN could pass it along to other residents and cause an outbreak. Record review of the facility's Wound Care Policy revised October 2010 revealed the steps 4-6 in the wound care procedure listed: 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely.