STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676384	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Sugar Land	1803 Wescott Avenue Sugar Land, TX 77479

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 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 one of six residents reviewed (Resident #18) for pressure ulcers. 1. The facility failed to ensure Resident #18 received services and treatment orders to prevent sacral pressure ulcers from healing. These failures could place residents at risk for worsening of existing wounds or development of new pressure ulcers. The findings were: Record review of Resident #18's face sheet, dated 09/21/2024, revealed an admitted [DATE], with diagnoses That included: encephalopathy tracheostomy, respiratory failure with hypoxia (low levels of oxygen in your tissues) or hypercapnia (high levels of carbon dioxde in your blood), osteomyelitis of vertebra (a bone infection that causes inflammation and swelling in the bone and its surrounding tissues), sacral and sacrococcygeal region stage 4(a full -thickness skin loss that extends into the deep tissues, including muscle, tendons, ligaments cartilage or bone), cognitive communication deficit, muscle wasting and atrophy, not elsewhere classified, right lower leg, cerebral aneurysm (a bulge in a weakened artery wall in the brain that can fill with blood), not ruptured. Record review of Resident #18's quarterly MDS assessment, dated 09/18/2024, revealed Resident #18 BIMS score was blank which indicated cognitive impairment. Resident #18 required limited to extensive assistance with all ADL and pressure ulcer Record review of Resident #18 wound assessment form dated reflected 9/27/24 had, ;Cleanse Sacral With Ns, Pat Dried, Wound Care Md Apply Helicoil (Stem Cells, Adaptic, Tape And Cal Alginate With Dry Dressing To Be In Place Until 10/3/2024. Do Not Remove Stem Cells/Adaptic.Change Cal Alginateevery othe day and nd Prn, Dressing Changes Only If Soiled. Every Day Shift Every Other Day For Wound. Record review wound care dated 9/26/24 revealed the physician did measurement of sacral pressure ulcer which reflected length 6.9 CM, width 9.0 CM and depth 5.3cm (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Observation at 2:45PM on 9/24/24 revealed RN R performing Sacral wound treatment to Resident #18. RN R poured NS (Normal Saline) on 4 X4 gauze, cleaned the wound bed from outside in with wet gauze repeated it 3 times with moderate serous fluid, without changing gloves she picked up dry 4 x4 gauze, she pat and dry the sacral wound, picked up a sheet of calcium Alginate placed it on the dressing and placed a foam heel dressing on the dressing and taped it. Interview with RN R on 9/24/24 at 1:16 PM regarding wound care she just completed, RN R said she did a good job. She wanted the surveyor to tell her what she did wrong. Interview on 9/25/24at 3:35 PM with the DON via telephone and RN R, RN R said she admitted to the facility 2 weeks and she did not have any training on wound care. She said the facility did not have all the treatment stuff for the resident and she did talk to the DON, before using the heel foam dressing. RN R said the treatment was for every other day and it was not due yet that was why she was taking her time. When asked why she was cleaning the wound bed outside in she did not have any explanation and she knew it can cause infection. Interview with the treatment Physician on 9/26/24 at 2:00 p.m., hhe said he surgically debrided the sacral weekly and calcium alginate should be packed inside the wound. He said the facility needs nursing education on wound dressing. He said foam heel should not be used on sacral dressing. In an interview on 09/26/2024 at 4:20 PM the DON stated her expectation was for the nurses to follow Dr's orders. She stated not following orders could potentially affect the resident's health. She would have in-service and monitor the license staff. No policy and procedure regarding following Physician orders was provided by the DON at the time of exit from the facility.

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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** 16352 incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident #18) reviewed for incontinent care. 1. The facility failed to ensure CNA A separated Resident #18's labia, cleaned the foley catheter insertion site and performed proper hand hygiene during foley care for Resident #18. This failure could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #18's face sheet, dated 09/21/2024, revealed an admitted [DATE], with diagnoses That included: encephalopathy tracheostomy, respiratory failure with hypoxia (low levels of oxygen in your tissues) or hypercapnia (high levels of carbon dioxde in your blood), osteomyelitis of vertebra (a bone infection that causes inflammation and swelling in the bone and its surrounding tissues), sacral and sacrococcygeal region stage 4(a full -thickness skin loss that extends into the deep tissues, including muscle, tendons, ligaments cartilage or bone), cognitive communication deficit, muscle wasting and atrophy, not elsewhere classified, right lower leg, cerebral aneurysm (a bulge in a weakened artery wall in the brain that can fill with blood), not ruptured. Record review of Resident #18's quarterly MDS assessment, dated 09/18/2024, revealed Resident #18 BIMS score was blank which indicated cognitive impairment. Resident #18 required limited to extensive assistance with all ADLs and was continent of bladder with indwelling catheter and frequently incontinent of bowel. Record review of Resident #18 's care plan, dated 6/21/24, reflected, . The resident has an ADL self-care deficit .Interventions .Personal hygiene and Toilet use- Resident is totally dependent An observation on 09/24/24 at 2:22 p.m., revealed CNA A and CNA C entered Resident #18's room preparing to provide incontinence care. CNA A put on clean gloves and unfastened Resident #18's brief soaked with urine and serous fluid. CNA A said the indwelling catheter was leaking and she would let the nurse know . CNA A took a peri-wipe and cleaned resident's perineal area; she did not open the labia to wipe, did not clean indwelling catheter from the insertion. CNA C assisted to roll Resident #18 on her left side. CNA A took a peri-wipe and wiped in-between residents' rectal area and did not wipe around the buttocks. Interview with CNA A on 09/24/24 at 5:12 p.m. she stated she was supposed to open the labia to clean and around the buttocks. CN.A A said she was nervous. She stated she knew the importance of properly cleaning a resident and by not doing so, placed them at risk of infections and she had been working with the facility for about 2 months (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 09/27/24 at 02:00 p.m., she stated staff were to open labia and clean around residents' buttocks. She stated by not following proper peri care it placed residents at risk of urinary tract infections and she would be over seeing and monitoring incontinent care. Review of CNA A's skill checks dated 07/30/24 reflected she was competent in performing peri-care. Record review of the facility's policy titled, Perineal care, revised March 2017, reflected, .Wash and dry hands thoroughly .put on gloves .wash perineal are , wiping from front to back .Separate labia and wash area downward from front to back . Assist the resident to turn on her side .Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks .Rinse and dry thoroughly

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on observation, interview and record review, the facility failed to ensure that residents who needs respiratory care, including tracheotomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of two residents reviewed for tracheotomy care (Resident #5). The facility failed to ensure RN R used sterile technique during tracheotomy care and suctioning for Resident #5. These failures could place residents with a tracheotomy requiring suctioning at risk for respiratory infections, hospitalization s, and a decline in their quality of life. Findings included: Record review of Resident #5's face sheet dated 09/27/2024 revealed resident was admitted to the facility on [DATE], age [AGE] years old male. Resident #5 had diagnosis of Acute Respiratory Failure with Hypoxia (occurs when the body doesn't have enough oxygen in its tissues). Record review of Resident #5's MDS dated [DATE] revealed the BIMS assessment was not done. Further review revealed that the staff assessed Resident #5 on mental status and found he has short-term and long-term memory/recall ability problems; and severely cognitively impaired. Record review of Resident #5's Physician Orders reviewed 08/13/2024 revealed the following: Tracheostomy Care cuffed flex Shiley 6 with disposable inner cannula) as indicated every 12 hours and PRN. Observation on 09/24/2024 at 4:00pm revealed Resident #5 was in bed with audible moist breath sounds. RN R set up a clean field on the bedside table, checked oxygen saturation checked and it was 96%. RN R did not remove dirty gloves, used the same gloves, and picked up Trach Care Kit. RN R opened the sterile Trach Care Kit, using the same gloves picked up sterile 4x4 gauze, placed sterile gloves on the bedside table. She changed gloves without washing hands or using hand sanitizer, grabbed the sterile suction catheter kit tray, opened it, then doff gloves without washing hands, picked up the sterile gloves, don sterile gloves then picked up normal saline at Resident #5's bed side, poured it in the tray. RN R picked up the suction tubing from the sterile suction kit connected it to the suction machine at Resident #5's bed side. RN R, using the same gloves, removed tracheostomy inner canula, then re-inserted it to trach site. Cleaned the surrounding area of trach using the sterile 4x4 gauze and dipped the gauze in the normal saline three different times without changing gloves and preforming hand hygiene during the cleaning and changing of tracheostomy tubes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/2024 at 1:30 PM, RN R stated she did not wash her hands during trach care or do suctioning. She stated she should have used sterile technique throughout, and she was recently in-serviced on tracheostomy care but could not recall the date of in service. RN R did not disclose why she failed to use sterile technique. She stated she worked with Resident #5 often. RN R stated that using the technique she used placed the resident at risk for a respiratory infection. Interview on 09/25/2024 at 5:00 PM, the DON stated that staff had been in-serviced on tracheostomy in September 2024. The DON stated that RN R should have used sterile technique during tracheostomy care. The DON stated that using the technique RN R used could have placed the resident at risk for an infection. The DON stated that the facility's scheduled respiratory therapist is usually responsible be providing respiratory care, but the nurses are trained in the event that the respiratory therapy staff is not available. The DON stated that the respiratory therapy department primarily oversees the trach care, but she would be working with the respiratory therapy to ensure that nursing staff was held accountable as well. Review of the facility's policy titled Tracheostomy Care dated August 2013, read Aseptic technique must be used: during cleaning and sterilization of reusable tracheostomy tubes; during all dressing changes until the tracheostomy wound has granulated (healed); and during tracheostomy tube changes, either reusable or disposable. Gloves must be used on both hands during any or all manipulation of the tracheostomy. Sterile gloves must be used during aseptic procedures.

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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** 48605 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 5 residents (Resident #177) reviewed for pharmacy services. LVN A failed to administer Lacosamide (medicine used to treat seizures), and Hydralazine (medicine used to lower blood pressure); to Resident #177 at 7:00am as ordered by the physician. LVN A failed to administer the whole dose of Hydralazine and Carvedilol (medicines used to lower blood pressure); Baclofen (medicine used as skeletal muscle relaxants); Glycopyrrolate (treats chronic obstructive pulmonary disease); Doxycycline (medicine used bacterial infections); and Isosorbide (medicine used to treat uncontrolled arterial hypertension) to Resident #177 as ordered by the physician. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: Record review of Resident #177's face sheet dated 09/27/2024 revealed resident was admitted to the facility on [DATE], age [AGE] years old male. Resident #177 had diagnoses of Parkinson's Disease (a progressive neurodegenerative disease); Epilepsy (a chronic brain disorder that causes people to have repeated seizures); Muscle Generalized Weakness (a feeling of weakness in most areas of the body); Dysarthria and Anarthria (both speech disorders that affect the ability to coordinate and control the muscles used for speaking); Tracheostomy Status (a medical classification that refers to an artificial opening in the windpipe (trachea) created to help with breathing); Presence of Cardiac Pacemaker (small device that's implanted in the chest to regulate a slow heart rate); Muscle Wasting and Atrophy (the thinning or loss of muscle tissue); Cognitive Communication Deficit (a difficulty with communication that's caused by a disruption in cognition); Dysphagia Oropharyngeal Phase (a condition that occurs when there is a delay in the movement of food or liquid during the phase is when food or liquid is moved from the mouth to the upper esophageal sphincter); Contracture of the Right Elbow, Left Elbow Right Wrist, Left Wrist, Right Hand, Left Hand, Right Knee, and Left Knee, Contracture (a permanent or temporary tightening of muscles, tendons, skin, and nearby tissues that limits the normal movement of a joint or body part); Essential (Primary) Hypertension (high blood pressure that is multi-factorial and doesn't have one distinct cause); and Cellulitis (a bacterial infection that affects the skin). Record review of Resident# 177's quarterly MDS dated [DATE] revealed a BIMS score of 03 which indicated severely impaired cognition. It also revealed the resident needed total care assist with ADL with two to three staff assistance. Further review revealed resident had gastrostomy tube (also called a G-tube) for feeding. Record review of Resident #1's physician's order summary report revealed the following order: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order dated 07/16/2024, Lacosamide solution 10 mg/ml give 10 ml via g-tube two times a day (7:00am and 7:00pm) for anticonvulsants. order dated 09/11/2024, Hydralazine tablet 25 mg Give 2 tablet via g-tube three times a day (7:00am, 2:00pm, and 9:00pm) for hypertension related to essential (primary) hypertension order dated 07/16/2024, Baclofen tablet 5 mg Give 1 tablet by mouth three times a day (9:00am, 2:00pm, and 9:00pm) for musculoskeletal order dated 07/16/2024, glycopyrrolate tablet 1 mg Give 1 tablet via g-tube three times a day (9:00am, 2:00pm and 9:00pm) for antiasthmatic and bronchodilator agents order dated 07/16/2024, Isosorbide Dinitrate tablet 10 mg Give 1 tablet via g-tube three times a day a day (9:00am, 2:00pm, and 9:00pm) for hypertension order dated 09/12/2024, Doxycycline tablet 100 mg Give 1 tablet via g-tube every 12 hours (9:00am and 9:00pm) related to cellulitis, unspecified Observation on 09/25/2024 at 9:08am revealed G-Tube medication administration with LVN A for Resident # 177. LVN A prepared to administer Resident # 177 as she added Lacosamide solution 10 mg to a 30ml cup and mixed with water to dilute. LVN A crushed two Hydralazine tablet 25 mg, Baclofen tablet 5 mg, glycopyrrolate tablet 1 mg, Isosorbide Dinitrate tablet 10 mg, Doxycycline oral tablet 100 mg. Each medication was crushed separately and diluted with water in individual 30ml cups. LVN A did not administer the whole amount of the crushed medication leaving a significant amount medication in each of the five cups. As LVN A was leaving Resident #177's room the surveyor asked LVN A if she had completed the medication pass. LVN A confirmed that she had completed the medication pass. The surveyor showed the medication cups with medication to LVN A and the DON. LVN A stated that medication should be administered. LVN A returned to Resident #177 to correct the errors by adding additional water to each medication cup to ensure that Resident #177 received the remainder of the medications as ordered by the physician. LVN A did not disclose why the medications were administered late. LVN A stated that the physician was notified of the medications that were administered late and was instructed by the physician to continue to monitor Resident #177. Interview on 09/25/2024 at 12:05pm The DON stated that she recently started work at the facility, but she would be the individual responsible for overseeing and auditing if medication were administered timely. The DON stated that medications were to be checked for the correct dosage and route with each medication pass. The DON stated that medication should be administered at the ordered time, allowing staff an hour before and hour after. The DON stated that when medications was administered in error at the wrong time and wrong dose that it can cause serious, sometimes long-term effects to the resident. The DON stated that it was a safety concern, and she was able to follow up with LVN A related to G-tube medication administration. The DON stated that all nurses and MA staff have been trained and were knowledgeable of the medication administration policy. The DON stated that additional training will be provided. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/2024 at 2:00pm with LVN A, she stated that Lacosamide and Hydralazine were given later than scheduled time of 7:00am to Resident #177. LVN A also verbally acknowledged she initially failed to administer the ordered dose of five medications (Hydralazine, Baclofen, glycopyrrolate, Isosorbide Dinitrate, Isosorbide Dinitrate). LVN A stated that she would usually give all medications as ordered and did not disclose why she failed to administer the medications at the time of the medication pass observation. She stated that if the residents did not get the medications as ordered, then the resident will not have the desired effect of the medication, and it can have a negative effect on the resident. She stated she had been trained on G-Tube medication administration. LVN A stated that medication should be administered at the ordered time, giving staff an hour before and hour after. Record review of education/training record for LVN A related to g-tube care and medication administration was verified by the surveyor team. The last documented medication administration training was September 2024. Review of the facility's policy titled Medication and Treatment orders dated November 2014, read Medications shall be administered only upon the written order . The was not additional mention of to address administering meds timely and administering all the meds correctly.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on observation, interview, and record review, the facility failed to ensure that it was free of medication error rate of five percent (%) or greater. The facility had a medication error rate of 26% based on 8 errors out of 30 opportunities, which involved 1 of 5 residents (Resident #177) reviewed for medication errors. LVN A administered Lacosamide (medicine used to treat seizures), and Hydralazine (medicine used to lower blood pressure); to Resident #177 at 9:08am instead of 7:00am as ordered by the physician. LVN A administered the wrong dose of Hydralazine and Carvedilol (medicines used to lower blood pressure); Baclofen (medicine used as skeletal muscle relaxants); Glycopyrrolate (treats chronic obstructive pulmonary disease); Doxycycline (medicine used bacterial infections); and Isosorbide (medicine used to treat uncontrolled arterial hypertension) to Resident #177 as ordered by the physician. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: Record review of Resident #177's face sheet dated 09/27/2024 revealed resident was admitted to the facility on [DATE], age [AGE] years old male. Resident #177 had diagnoses of Parkinson's Disease (a progressive neurodegenerative disease); Epilepsy (a chronic brain disorder that causes people to have repeated seizures); Muscle Generalized Weakness (a feeling of weakness in most areas of the body); Dysarthria and Anarthria (both speech disorders that affect the ability to coordinate and control the muscles used for speaking); Tracheostomy Status (a medical classification that refers to an artificial opening in the windpipe (trachea) created to help with breathing); Presence of Cardiac Pacemaker (small device that's implanted in the chest to regulate a slow heart rate); Muscle Wasting and Atrophy (the thinning or loss of muscle tissue); Cognitive Communication Deficit (a difficulty with communication that's caused by a disruption in cognition); Dysphagia Oropharyngeal Phase (a condition that occurs when there is a delay in the movement of food or liquid during the phase is when food or liquid is moved from the mouth to the upper esophageal sphincter); Contracture of the Right Elbow, Left Elbow Right Wrist, Left Wrist, Right Hand, Left Hand, Right Knee, and Left Knee, Contracture (a permanent or temporary tightening of muscles, tendons, skin, and nearby tissues that limits the normal movement of a joint or body part); Essential (Primary) Hypertension (high blood pressure that is multi-factorial and doesn't have one distinct cause); and Cellulitis (a bacterial infection that affects the skin). Record review of Resident# 177's quarterly MDS dated [DATE] revealed a BIMS score of 03 which indicated severely impaired cognition. It also revealed the resident needed total care assist with ADL with two to three staff assistance. Further review revealed resident had gastrostomy tube (also called a G-tube) for feeding. Record review of rResident #1's physician's order summary report revealed the following order: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order dated 07/16/2024, Lacosamide solution 10 mg/ml give 10 ml via g-tube two times a day (7:00am and 7:00pm) for anticonvulsants. order dated 09/11/2024, Hydralazine tablet 25 mg Give 2 tablet via g-tube three times a day (7:00am, 2:00pm, and 9:00pm) for hypertension related to essential (primary) hypertension order dated 07/16/2024, Baclofen tablet 5 mg Give 1 tablet by mouth three times a day (9:00am, 2:00pm, and 9:00pm) for musculoskeletal order dated 07/16/2024, glycopyrrolate tablet 1 mg Give 1 tablet via g-tube three times a day (9:00am, 2:00pm and 9:00pm) for antiasthmatic and bronchodilator agents order dated 07/16/2024, Isosorbide Dinitrate tablet 10 mg Give 1 tablet via g-tube three times a day a day (9:00am, 2:00pm, and 9:00pm) for hypertension order dated 09/12/2024, Doxycycline tablet 100 mg Give 1 tablet via g-tube every 12 hours (9:00am and 9:00pm) related to cellulitis, unspecified Observation on 09/25/2024 at 9:08am revealed G-Tube medication administration with LVN A for Resident # 177. LVN A prepared to administer Resident # 177 as she added Lacosamide solution 10 mg to a 30ml cup and mixed with water to dilute. LVN A crushed two Hydralazine tablet 25 mg, Baclofen tablet 5 mg, glycopyrrolate tablet 1 mg, Isosorbide Dinitrate tablet 10 mg, Doxycycline oral tablet 100 mg. Each medication was crushed separately and diluted with water in individual 30ml cups. LVN A did not administer the whole amount of the crushed medication leaving a significant amount medication in each of the five cups. As LVN A was leaving Resident #177's room the surveyor asked LVN A if she had completed the medication pass. LVN A confirmed that she had completed the medication pass. The surveyor showed the medication cups with medication to LVN A and the DON. LVN A stated that medication should be administered. LVN A returned to Resident #177 to correct the errors by adding additional water to each medication cup to ensure that Resident #177 received the remainder of the medications as ordered by the physician. LVN A did not disclose why the medications were administered late. LVN A stated that the physician was notified of the medications that were administered late and was instructed by the physician to continue to monitor Resident #177. Interview on 09/25/2024 at 12:05pm The DON stated that she recently started work at the facility, but she would be the individual responsible for overseeing and auditing if medication were administered timely. The DON stated that medications were to be checked for the correct dosage and route with each medication pass. The DON stated that medication should be administered at the ordered time, allowing staff an hour before and hour after. The DON stated that when medications was administered in error at the wrong time and wrong dose that it can cause serious, sometimes long-term effects to the resident. The DON stated that it was a safety concern, and she was able to follow up with LVN A related to G-tube medication administration. The DON stated that all nurses and MA staff have been trained and were knowledgeable of the medication administration policy. The DON stated that additional training will be provided. (continued on next page)

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	676384	A. Building B. Wing	09/27/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/2024 at 2:00pm with LVN A, she stated that Lacosamide and Hydralazine were given later than scheduled time of 7:00am to Resident #177. LVN A also verbally acknowledged she initially failed to administer the ordered dose of five medications (Hydralazine, Baclofen, glycopyrrolate, Isosorbide Dinitrate, Isosorbide Dinitrate). LVN A stated that she would usually give all medications as ordered and did not disclose why she failed to administer the medications at the time of the medication pass observation. She stated that if the residents did not get the medications as ordered, then the resident will not have the desired effect of the medication, and it can have a negative effect on the resident. She stated she had been trained on G-Tube medication administration. LVN A stated that medication should be administered at the ordered time, giving staff an hour before and hour after. Record review of education/training record for LVN A related to g-tube care and medication administration was verified by the surveyor team. The last documented medication administration training was September 2024. Review of the facility's policy titled Medication and Treatment orders dated November 2014, read Medications shall be administered only upon the written order . The was not additional mention of to address administering meds timely and administering all the meds correctly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 16352 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen when they failed to: A. Ensure stored food was properly labeled, dated, and contained. B. Ensure general cleanliness was maintained. C. Ensure substitution list, cleaning list and temperature logs were utilized. These failures could place all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings include: Observations on 9/23/24 at 09:33 am, during initial kitchen rounds of the freezer by the stove revealed: 1. Hash brown in a box not labeled and not dated 2. 5-way mixed vegetable, not labeled or dated, and not in the original box. 3. Vegetable egg rolls in original container 3 pounds box open not dated 4. Beyond chicken tenders 2.5 pounds in box not dated in original package 5. Vegetable egg rolls in original container 3 pounds box open not dated Observations on 9/23/24 at 09:33 am, during initial kitchen rounds of the standing oven the grill revealed: 1. Standing oven by the grill had dry food particles, sticky and grime. In an interview with the DM on 9/23/ 24 at 10:00AM, he said he normally scheduled employee to clean the oven, he was not sure when it was last cleaned. He said did not have a cleaning log. He thought it was last cleaned a week before. DM said he would start keeping a cleaning log. Interview on 9/27/2024 at 1:39pm with the Administrator, she said she was informed that the food was not labeled. She said her expectations for her staff was to have the food dated, labeled including discard date to be thrown out if the dates have passed on the item. She said she was told inside the oven it was brown. She said her expectations moving forward for the staff was to have the oven cleaned after every use. She said by having her staff clean the oven after each use it would guarantee that the oven will not have any particles left over. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the (Revised date November 2022) facility policy titled ' Food Receiving and storage . Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen or discarded, food items that remain sealed from the supplier may be held until the expiration date if unopened. Food returning to storage after Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 16352 Based on observation, interview and record review, the facility failed to ensure garbage and refuse was disposed properly for 1 of 1 dumpster reviewed for garbage disposal. -The facility failed to ensure the dumpster floor were free of debris. This failure could place residents at risk of infection from improperly disposed garbage. Findings include: Observation and Interview on 9/24/24 at 12:20 PM with Housekeeper A, revealed around the dumpster, behind and the side of the dumpster had lots of debris of paper, diaper, leaves, woods, and a broken dresser. Housekeeper A asked the surveyor Is the company the picks up the dumpster supposed to swipe the debris around the dumpster or the facility? Surveyor advised her to check with her supervisor. Interview on 9/24/24 at 2:06 PM with the Director of housekeeping, he said he has been working in the facility since March 2024. He said he was not aware of the debris behind the dumpster and by the side. He said he had not check around the dumpster. He said he was told by the housekeeping staff and the dumpster was picked up 3 times a week on Tuesdays, Thursday, and Saturday. He said the company just picked the dumpster up earlier today, he was not aware the dumpster had all that trash behind. He stated that he did not expect the debris around the dumpster because it can bring critters, rodents and rats. He said he was going sweep around dumpster and he would be checking on it often. Interview on 9/24/24 at 5:30 PM with the Administrator, she said she expected the dumpster, to be closed and the surrounding to be free of debris and trash. Administrator said she would be monitoring it every other day. Record review of the facility policy and procedure dated (revision October 2017) Food-Related Garbage and refuse Disposal . 5.Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests.6. Storage areas will be kept clean at all times and shall not constitute a nuisance.7. Outside dumpster provided by garbage pick up services will be kept closed and free of surrounding litter.

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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** 16352 Based on observations, interviews, and record reviews, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 5 residents (Resident #18) reviewed for infection control, in that: CNA A did not change her gloves or wash her hands after providing incontinent care to Resident #18. RN R did not change her gloves or wash her hands during pressure ulcer treatment and after providing treatment to Resident #18 RN R did not change her gloves or wash her hands and used sterile technique during tracheotomy care and suctioning for Resident #5. These failures could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #18's face sheet, dated 09/21/2024, revealed an admitted [DATE], with diagnoses that included: encephalopathy tracheostomy, respiratory failure with hypoxia or hypercapnia, osteomyelitis of vertebra, sacral and sacrococcygeal region stage 4 pressure ulcer, cognitive communication deficit, muscle wasting and atrophy, not elsewhere classified, right lower leg, cerebral aneurysm, not ruptured. Record review of Resident #18's quarterly MDS assessment, dated 09/18/2024, revealed Resident #18 BIMS score was blank which indicated cognitive impairment. Resident #18 required limited to extensive assistance with all ADLs and was continent of bladder with indwelling catheter and frequently incontinent of bowel. Review of Resident #18's care plan dated 06/23/2024, revealed a problem of The resident has Urinary Tract Infection, with an intervention of Provide incontinence care as needed. Record review of the physician order dated 9/23/24 revealed Physician's order for Resident #18 Fosfomycin Tromethamine Oral Packet 3 GM (Fosfomycin Tromethamine) Give 3 gram via G-Tube every 72 hours for UTI until 10/03/2024. Observation on 09/24/24 at 1:06 p.m. while RN R was providing pressure ulcer treatment to Resident #18, RN R did not wash her hands before donning gloves, she removed the old dressing to left ear that was bleeding, without changing gloves she picked up clean 4 X4 gauzes , and placed 4 x4 gauzes in a clean cup then poured in normal saline, then picked the wet gauzes and cleaned the wound about 4 times to left [NAME], she then used the same gloves, picked up a scissor cut the Xerofoam dressing and applied to left ear and boarder dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/24/24 at 2:22 p.m., revealed, while providing incontinent care for Resident #18, CNA A did not wash her hands when she entered Resident #18's room to provide incontinent care, don clean gloves. C.NA A did not change her gloves or wash her hands after providing incontinent care for Resident #18 and before touching and fastening the clean brief to Resident #18. During an interview on 9/24/2024 at 5:12 p.m. CNA A confirmed she did not change her gloves or wash her hands prior to touching the clean brief. She said she was nervous. She confirmed she received infection control training 1 month ago when she was hired. Record review of Resident #5's face sheet dated 09/27/2024 revealed resident was admitted to the facility on [DATE], age [AGE] years old male. Resident #5 had diagnosis of Acute Respiratory Failure with Hypoxia (occurs when the body doesn't have enough oxygen in its tissues). Record review of Resident #5's MDS dated [DATE] revealed the BIMS assessment was not done. Further review revealed that the staff assessed Resident #5 on mental status and found he has short-term and long-term memory/recall ability problems; and severely cognitively impaired. Observation on 09/24/2024 at 4:00pm revealed Resident #5 was in bed with audible moist breath sounds. RN R set up a clean field on the bedside table, checked oxygen saturation checked and it was 96%. RN R did not remove dirty gloves, used the same gloves, and picked up Trach Care Kit. RN R opened the sterile Trach Care Kit, using the same gloves picked up sterile 4x4 gauze, placed sterile gloves on the bedside table. She changed gloves without washing hands or using hand sanitizer, grabbed the sterile suction catheter kit tray, opened it, then doff gloves without washing hands, picked up the sterile gloves, don sterile gloves then picked up normal saline at Resident #5's bed side, poured it in the tray. RN R picked up the suction tubing from the sterile suction kit connected it to the suction machine at Resident #5's bed side. RN R, using the same gloves, removed tracheostomy inner canula, then re-inserted it to trach site. Cleaned the surrounding area of trach using the sterile 4x4 gauze and dipped the gauze in the normal saline three different times without changing gloves and preforming hand hygiene during the cleaning and changing of tracheostomy tubes. Interview on 09/25/2024 at 1:30 PM, RN R stated she did not wash her hands during trach care or do suctioning. She stated she should have used sterile technique throughout, and she was recently in-serviced on tracheostomy care but could not recall the date of in service. RN R did not disclose why she failed to use sterile technique. She stated she worked with Resident #5 often. RN R stated that using the technique she used placed the resident at risk for a respiratory infection. Interview on 09/25/2024 at 5:00 PM, the DON stated that staff had been in-serviced on tracheostomy in September 2024. The DON stated that RN R should have used sterile technique during tracheostomy care. The DON stated that using the technique RN R used could have placed the resident at risk for an infection. The DON stated that the facility's scheduled respiratory therapist is usually responsible be providing respiratory care, but the nurses are trained in the event that the respiratory therapy staff is not available. The DON stated that the respiratory therapy department primarily oversees the trach care, but she would be working with the respiratory therapy to ensure that nursing staff was held accountable as well. (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 with the DON on 09/26/2024 at 3:15 p.m., the DON confirmed gloves must be changed after cleaning and before touching clean brief to prevent cross contamination. The DON revealed she was training the staff for infection control. DON just started working one week and would be monitoring the staffs. Interview on 9/27/24 at 1:39 PM with the Administrator, she said she expected for Incontinent care and Foley care done by the staffs to prevent infection. She said she was informed by DON about peri care the foley insertion site was not cleaned properly. She said her expectations was for the staff to clean all the areas including the foley insertion area thoroughly. She said the staff should be using multiple cleansing wipes. She said she was informed staff was cleaning from the outside in which causes contamination. She said her expectation was for the staff to clean inside out and not to re-wipe areas that have already been cleaned. She said it was important to determine which hand will be clean and which hand will be dirty. She said infection control hands on competencies in a classroom setting referencing trach and wound care with verbal and return demonstrations. She said they will perform weekly trach care and wound care audits x 8 (2 months) and re-evaluate staff after all training was completed. Review of the facility policy, titled Fundamental of infection control precautions, dated 2019, revealed [.] the following is a list of some situations that require hand hygiene: [.] Before and after direct resident contacts (for which hand hygiene is indicated by acceptable professional practice) [.] after contact with a resident's mucous membranes and body fluids or excretions.