

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Woodlands Place Rehabilitation Suites		STREET ADDRESS, CITY, STATE, ZIP CODE 5600 Woodlands Trail Denison, TX 75020	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918</p> <p>Based on interview, observation and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for one of six residents (Residents #8) reviewed for pharmacy services.</p> <p>The facility failed to ensure LVN C followed the Physician orders and facility procedures for checking residual before administering Resident #8's medication through his g-tube on 12/04/24.</p> <p>This failure placed the residents at risk of aspiration, vomiting or incomplete administration of medication if tube was blocked or obstructed.</p> <p>Findings included:</p> <p>Record review of Resident #8's quarterly MDS assessment dated [DATE], reflected a [AGE] year-old male with an admitted [DATE]. Staff assessment for mental status reflected resident was moderately cognitively impaired. The resident received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Diagnoses included cerebral palsy (a congenital disorder of movement, muscle tone or posture due to abnormal brain development).</p> <p>Record review of Resident #8's physician order report dated 11/05/24 through 12/05/24, reflected, . Placement Verification by aspiration of stomach residual volume . with a start date of 08/01/24.</p> <p>Record review of Resident #8's care plan updated on 11/07/24 reflected, [Resident #8] is at nutrition and dehydration risk related to tube feeding .Approach .Medications as ordered via g tube .Monitor for signs/symptoms of tube feeding intolerance .</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A medication pass observation on 12/04/24 at 08:55 a.m. revealed LVN C at the medication cart preparing Resident #8's medication for g-tube administration. LVN C prepared 4 medications placing each of the medications into separate plastic medication cups and diluted the 2 non-liquid medications with 5 ml of water. LVN C entered the resident's room and obtained a cup of water from the resident's bathroom and turned off the G-tube pump. LVN C then checked placement of the G-tube through air auscultation but did not pull back to check for residual. LVN C flushed the G-tube with 30 ml of water and administered the 4 medications, flushed with water between each medication and then flushed with 30 ml after the last medication. LVN C then re-connected the Enteral feeding line and turned the pump back on.</p> <p>In an interview on 12/04/24 at 09:15 a.m. LVN C stated she was supposed to check placement with air auscultation. She stated they no longer had to check residual. LVN C then reviewed the orders and stated she had gotten it backwards; she was supposed to check residual for placement not air auscultation. She stated the risk for not checking residual was if the resident had too much residual, they would need to hold the medications and let the physician know. She stated it could cause aspiration if the stomach was overfilled.</p> <p>In an interview on 12/05/24 at 11:15 a.m. with the DON stated the nurse just got it backwards. She stated LVN C was one of the best nurses for G-tube medication administration. She stated she was an old school nurse who was taught to check with air auscultation, but stated they also had to check residual to determine if they needed to hold the feeding or medication. She stated the risk of not checking was aspiration. She stated they did skills checks on all the staff annually or if they determine they need additional training or procedures.</p> <p>Record review of LVN C Staff Education/Orientation check off list dated 10/16/24 reflected she had met the performance criteria for Gastrostomy tube management.</p> <p>Record review of the Facilities undated procedure, Enteral Tube Drug instillation, reflected, .Verify enteral tube placement using at least two of the following. Observe for a change in the external tube length or the incremental marking at the exit site .Aspirate tube contents and inspect the visual characteristics of the tube aspirate .Notify the practitioner if tube placement is in doubt .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50910</p> <p>Based on observations, interviews and record review, the facility failed to store and label food in accordance with professional standards for food service safety for the facility's only kitchen in that:</p> <p>The facility failed to ensure food items in the facility refrigerator and freezer were dated or labeled.</p> <p>The facility failed to take the temperature of the soup after re-heating the soup in the microwave.</p> <p>These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination.</p> <p>Findings Include:</p> <p>*At 8:45am revealed an opened box of slice smoked ham had two plastic 3-pound bags of sliced smoked ham without a date received or date used by.</p> <p>*At 8:49am revealed an unopened loaf of white sliced bread in non-labeled clear bag without a date used by or label of contents.</p> <p>Observation of facility's kitchen walk-in freezer on [DATE] revealed the following:</p> <p>*At 8:49am revealed 2 apple lattice pies in individual boxes that were opened to the air and not securely closed.</p> <p>*At 8:49am revealed an opened bag of about 35 unidentified frozen little squares was in a box labeled 10 pounds of chicken breast tenders had no label of what it was or date used by.</p> <p>Interview with Dietary Manager on [DATE] at 8:49am revealed her expectation was that everything be labeled with date received and that the items had to be used within 14 days of receipt. She stated once an item was opened, they must write the date of open and it had to be used within 3 days of opening. She stated she could not find a date on the box of smoked ham or a date and label of what the item was on the bag that looked like bread. She stated the loaf must have been the last one in the box and they took it out and threw the box away. She stated not labeling items appropriately posed a risk by possibly making a resident sick due to them being expired. She indicated the pies should have been securely covered so they would not get freezer burn; she grabbed them to discard them. She identified the bag of small squares in the box of chicken strips as tater tots and stated that because they were not labeled it would put the residents at risk, as they would be served the wrong items.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of food preparations on [DATE] at 11:10am revealed the Dietary Manager had warmed an individual cup of soup in the microwave, she took the temperature and rewarmed it. Observation revealed the Dietary Manager took the temperature of the soup after reheating it in the microwave. She then told the rest of the staff they needed to warm individual servings of soup for 2 minutes to ensure it was warmed to the appropriate temperature. Observation revealed 3 more individually served soups were served by kitchen staff without temperatures taken.</p> <p>Interview with Dietary Manager on [DATE] 12:34 PM revealed she had temped the individually served soup at 180 degrees after reheating it in the microwave. Interview revealed the Dietary Manager warmed the soup for 2 minutes in the microwave and instructed the rest of the staff to warm all the individually served soups at 2 minutes in the microwave after that. She stated the expectation was for all food to be temped before being served and that included the individually served soups. She stated not having the appropriate temperature on the soups would not kill all possible bacteria.</p> <p>Record review of Nutritional Policies and Procedures revised [DATE] reflected, General Food Storage Guidelines .12. Refrigerated, ready to eat Time/Temperature Control (TCS) for Safety Foods are properly covered, labeled, dated with a use-by date, and refrigerated immediately. [NAME] them clearly to indicate the date by which the food shall be consumed or discarded. The day of preparation or day original container is opened shall be considered day 1. Follow USDA guidelines for food storage</p> <p>Review of the facility policy Food Safety in Receiving and Storage dated [DATE] revealed Refrigerated Storage Guideline 4. Maintain the ambient temperature of refrigerator to 34 to 40 degrees Fahrenheit</p> <p>Review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE]. 11 Food Storage.(B) .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</p> <p>Review of the Food and Drug Administration Code, dated 2022, reflected ,d+[DATE].11 Reheating for Hot Holding (A) . Time/temperature Control for Safety food that is cooked, cooled , an reheated for hot holding shall be reheated so that all parts of the food reaches a temperature of at least 74 degrees Celsius (165 degrees Fahrenheit) and the food is rotated or stirred, covered and allowed to stand covered for 2 minutes after reheating .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34918</p> <p>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 communicable diseases and infections for 3 of 12 residents (Resident #21, Resident #63, and Resident #45) observed for infection control.</p> <ol style="list-style-type: none"> The facility failed to ensure RN B prepared Resident 21's medication without cross contaminating her medications on 12/04/24 The facility failed to ensure that CNA D performed hand hygiene after providing dressing assistance and transfer of Resident # 63 and before leaving the resident's room on 12/04/24. The facility failed to ensure that CNA F changed her gloves and performed hand hygiene while providing incontinence care to Resident #45 on 12/04/24 and failed to ensure CNA F and CNA E performed hand hygiene after completion of incontinence care on Resident #45, before leaving the room on 12/04/24 <p>These failures could place the residents at risk of cross-contamination and development of infection.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During medication observation on 12/04/24 at 08:30 a.m. RN B was observed at the medication cart. RN B performed hand hygiene without putting on gloves and entered Resident #21's room to obtain her blood pressure, temperature, and Oxygen saturation levels. RN B returned to the medication cart, put on a pair of gloves, and sanitized the equipment with a germicidal wipe. RN B then removed her gloves and returned to the resident's room to wash her hands. RN B then put on a glove on her right hand and opened the medication cart with her gloved hand and pulled out the resident's each of the required over the counter supplements and poured the medication into the top of the supplement bottle and then placed them in a plastic medication cup. RN B then pulled out seven blister packs, and proceeded to pop the medication into her gloved hand and then placed each tablet into the medication cup with her gloved hand. RN B stated she had to go to the medication room to pull one of the resident's medications. RN B placed the medication cup in the top drawer of the medication cart, locked it and started walking down the hall, still wearing the glove on her right hand. RN B then removed the gloved, entered the Medication room, disposed the glove, and opened the refrigerator and the lock box inside of the refrigerator and retrieved 1 tablet of Dronabinol (cannabinoids used for nausea and loss of appetite). She then searched the cabinet for a multi vitamin and then returned to the medication cart. RN B then put on another glove on her right hand without performing hand hygiene and opened the medication cart and pulled out the plastic cup containing the resident's medications and continued popping the Dronabinol and one other medication from the blister pack into her gloved hand and placed them into the medication cup. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/04/24 at 08:55 a.m. with RN B she stated she thought she was being extra cautious on infection control by using the glove. She stated she had been told during Inservice to be sure they did not touch the top of the medication cup while popping the meds out of the blister pack to prevent cross contamination. She stated it was so hard to pop the pills out of the pack without touching the top of the cup, so she thought popping it into her gloved hand would prevent that problem. She stated after the thought about that process, she realized she had cross contaminated the glove once she touched other items on and in the medication cart. She stated she today (12/04/24) was the first time she had punched the medications into her gloved hand. RN B entered the resident's room and administered the medication. Removed her glove and performed hand hygiene.</p> <p>In an interview on 12/05/24 at 11:10 a.m. with the DON she stated staff had never been taught to punched meds into a gloved hand. She stated they were taught to punch the medication directly into the med cup without touching the medication to prevent cross contamination. She stated she saw RN B with the glove on her hand and could not figure out why she would be wearing a glove. She stated the go over and over infection control practice with the staff. She stated she had never seen RN B pass medications the way she had during the observation and stated it was certainly not the facility policy or procedure.</p> <p>Record review of RN B's staff education/orientation check list dated 10/15/24 reflected she had met the performance criteria for medication administration.</p> <p>Record review of the facility's policy titled, Medication Management Program, dated May 2023, reflected, . The authorized staff member or licensed nurse will retrieve refrigerated items needed for administration prior to initiate the medication pass .Administering the Medication pass .Perform hand hygiene .Do not touch the mediation when opening a bottle or unit dose package .</p> <p>2. An observation on 12/04/24 at 11:10 a.m. revealed CNA D entered Resident #63's room to transfer him to the wheelchair. CNA D performed hand hygiene and put on gloves and a gown. CNA D removed the residents hospital gown and placed the resident's leg urinary drainage bag into the leg of his pants and then placed the resident's other leg into his pants. CNA D then put on the resident's shirt and assist him to sit up on the side of the bed. CNA D placed a gait belt around the resident and transferred him to the wheelchair. CNA D then placed the dirty gown into a plastic bag and then pushed the resident toward the door, stopped to remove his gown and gloves and left the resident's room without performing hand hygiene. He then pushed the resident while holding the plastic bag which contained soiled clothing, to the front office for his care plan conference.</p> <p>In an interview on 12/04/24 at 11:25 a.m. with CNA D he stated he was supposed to perform hand hygiene after he removed his gloves and gown and before he left the room. He stated he just forgot since he knew the residents care plan was scheduled for 11:30 a.m. and he was trying to get him there on time. He stated the risk of not performing hand hygiene was the spread of germs.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. In an observation on 12/04/24 at 03:40 p.m. CNA E and CNA F put on a gown and entered Resident #45's to provide incontinence care. Both staff entered the resident's room and washed their hands and put on gloves. Both staff unfastened the resident's brief, CNA F cleaned the resident from front to back, changing her wipes with each stroke. CNA F then removed her gloves and washed her hands. Both staff assisted the resident onto her side and CNA F cleaned the residents' anal area from front to back revealing she had a small soft bowel movement. CNA F wiped several times changing out the wipe each time. CNA F then placed the clean brief under the resident without changing her gloves or performing hand hygiene. CNA E removed her gloves and washed her hands, put on gloves and then assisted to roll the resident back onto her other side to remove the soiled brief and pull the clean brief under the resident. Both staff adjusted the resident covers and lowered her bed. Both staff removed their gowns and gloves and placed them in the plastic bag with the soiled briefs and wipes and left room without performing hand hygiene.</p> <p>In an interview at 12/04/24 at 04:00 p.m. with CNA E and CNA F they both stated they were supposed to perform hand hygiene when they went from dirty to clean and were supposed to wash their hands before they left the room. Both staff members stated they had failed to do that. Both staff members stated the risk of not performing hand hygiene was the spread of infection to other residents.</p> <p>In an interview with ADON A on 12/05/24 at 09:47 a.m. she stated she was the infection preventionist. She stated staff were always taught to sanitize their hands when they enter a resident's room, when going from dirty to clean and before leaving the resident's room. She stated the do skills checks at time of hire, annually and as needed if they determine an issue. She stated the Charge nurse are also expected to observe staff for compliance with infection control practices.</p> <p>In an interview on 12/05/24 at 11:10 a.m. with the DON she stated staff were supposed to wash hands and change gloves before, and after completion of cleaning a resident and after completion of care. She stated they had worked so hard with the staff on skills and stated they were all aware of what they were supposed to be doing. She stated the risk of failing to perform hand hygiene was increased infections and cross contamination.</p> <p>Record review of CNA E's competency check off for peri-care revealed she was proficient in care as of 11/04/24.</p> <p>Record review of CNA F's competency check off for peri-care revealed she was proficient in care as of 11/04/24.</p> <p>Record review of the facility's policy titled, Hand Hygiene/Handwashing, dated May 2023, reflected, .Hand Hygiene/Hand washing is the most important component for preventing the spread of infection .Hand hygiene/hand washing is done before .patient/resident contact .before taking part in a medical or surgical procedure .After contact with soiled or contaminated articles, such as articles that are contaminated body fluids .After patient/resident contact . After removal of medical/surgical gloves or utility gloves .Contact with environmental surfaces in the immediate vicinity of patients/residents .</p>		