STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676434	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on interview and record review, the facility failed to immediately inform or consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complication) for 1 of 10 residents (CR #1) reviewed for physician notification. LVN A failed to notify or seek clinical guidance from CR #1's physician, or any physician when she observed him in respiratory distress and had an oxygen saturation (blood oxygen level) of 73% upon admission to the facility from a rehabilitation hospital on [DATE]. This failure resulted in no communication/guidance from CR #1's physician and LVN A being unaware of CR #1's intermittent shortness of breath and respiratory distress throughout the day before he was found unresponsive between 6:00 p.m. and 7:00 p.m. and subsequently expired. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 10:30 a.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on [DATE]. This failure placed residents who experience a change of condition at risk of further deterioration and death. Findings include: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's face sheet dated [DATE] revealed he was a [AGE] year-old male who was admitted to the facility from a rehabilitation hospital on [DATE]. He was diagnosed with chronic congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), atherosclerotic heart disease (damage or disease in the heart's major blood vessels which causes the buildup of plaque), diabetes (a group of diseases that result in too much sugar in the blood) with polyneuropathy (damage or disease affecting peripheral nerves in roughly the same areas on both sides of the body which causes weakness, numbness, and burning pain), chronic kidney disease, stage 3 (when the kidneys have mild to moderate damage and are less able to filter waste and fluid from the blood), venous insufficiency (improper functioning of the vein valves in the leg which causes swelling and skin changes), enterocolitis due to recurrent clostridium difficile (inflammation of the colon and large intestine caused by bacteria), cardiac arrest (sudden, unexpected loss of heart function, breathing, and consciousness), essential hypertension (a form of hypertension [a condition in which the force of the blood against the artery walls is too high]without an identifiable physiologic cause), transient cerebral ischemic attack (a brief stroke -like attack that resolves within minutes to hours), sepsis (a life-threatening complication of an infection), acute respiratory failure with hypoxia (a medical emergency that occurs when the body does not have enough oxygen in its tissues and causes shortness of breath, confusion, cardiac dysfunction, and cardiac arrest), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). He was discharged from the facility on [DATE]. Record review of CR #1's entry MDS dated [DATE] revealed it only contained his personal information, such as his date of birth, marital status, insurance information, and date of admission. Record review of CR #1's electronic clinical record revealed no documentation of a care plan. Record review of CR #1's physician's orders revealed he was not prescribed scheduled or PRN oxygen therapy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's clinical records from the rehabilitation hospital dated [DATE] revealed he was admitted to the rehabilitation hospital from an acute care hospital on [DATE], and he was discharged to the facility on [DATE]. The document reflected, . History: This patient is a [AGE] year-old male who lived with a family member, previously independent. He has had multiple hospitalization s over the last several months, he had been here twice before. The first time was for recovery from total hip replacement, but he was transferred out acutely for change in his overall status and patient developed C. diff and a right lower extremity wound, which he currently has a wound vacuum. The patient was discharged home with family, but readmitted to acute care on [DATE] with complaints of diarrhea . He was admitted and followed for relapse of C. diff colitis . He was also followed for acute on chronic renal failure. No other major medical complications, but he remains quite weak . He has an indwelling catheter . [DATE], Cardiology Progress Note. Subjective: Patient seen and examined in the room, denies chest pain, no shortness of breath, no palpitations (feelings of fast-beating, fluttering, or pounding heart), no dizziness or syncope (fainting, or sudden temporary loss of consciousness), no orthopnea (discomfort when breathing while lying down flat), no nausea, vomiting, or diarrhea . [DATE], at 9:37 a.m.: oxygen saturation 99% . [DATE], at 4:15 p.m.: oxygen saturation 95% . Respiratory: Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal . [DATE]: Remains on isolation protocol. Still gets drowsy, requires full oxygen support (no details provided) . [DATE], at 1:39 p.m. - Treatment Session Conclusion - Patient Status: Location - Transport: Left in room, call light within reach, bedside table within reach (Comment: catheter intact, 2L O2 via nasal cannula .) . Further review of CR #1's medical records revealed no other documentation of oxygen administration or physician's orders for oxygen therapy. Record review of CR #1's progress notes for [DATE] revealed: view draft (typed in red). Effective date: [DATE], 7:15 p.m. LVN A wrote, Note Text: 12:15 p.m.: [CR #1] was a new admit who arrived via EMS. He was accompanied by [several family members]. Resident was transferred by EMS from stretcher to bed by EMS x 2 assist. EMS woman giving report stated that resident was on isolation for C-diff and may also have COVID. Initial assessment O2 saturation at ,d+[DATE]% (according to medicinenet.com, sustained blood oxygen levels below ,d+[DATE]% can be life-threatening and may lead to death if not addressed promptly) room air, ,d+[DATE] [blood pressure], 73 [pulse]. Writer immediately directed to staff to bring a tank of oxygen and a concentrator to room. This nurse informed family that their loved one did not look too good, and that his O2 was a concern. Writer initiated O2 on 5L and decreased. Resident O2 saturation was accomplished with a reading of ,d+[DATE]% on 3L. Resident became more aroused and verbal. He communicated with writer and said that he [would] like to be addressed by his first name. Throughout assessment, EMS had already left the building. They did not ensure that resident was connected to oxygen prior to leaving. During assessment, family remained at bedside and answered questions from this nurse . Resident was provided lunch, writer noted that resident had only eaten approximately 50%. Family member stated that CR #1 did not eat much. Last time writer saw CR #1 prior to him coding, was roughly ,d+[DATE] hours earlier at approximately ,d+[DATE] p.m. Resident was quietly watching television and did not appear to be in any distress. Bed semi-Fowler (a medical position where a patient lies on their back with their head and upper body raised at a ,d+[DATE]-degree angle on the bed). Breathing non-labored. Therapist notified this nurse that resident [was] non-responsive. Nurse immediately called a code blue before getting in room. Upon arrival in room, nurse noted resident non-responsive and initiated CPR. Two nurses and several staff in room and assisted nurse with CPR and AED. 911 notified. CPR continued until 911 arrived and took over. Family members arrived five minutes behind. Resident pronounced (CR #1's death was announced) at 7:35 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the DON on [DATE], at 9:45 a.m., she stated CR #1 was admitted to the facility on Sunday, [DATE] around 12:00 p.m. then coded and passed away around 6:00 p.m. that same day. She said, according to LVN A, CR #1 did not look well, and his oxygen saturation was in the lower 70's when EMS transferred him from the gurney (stretcher) to the bed. She said to her knowledge, EMS brought CR #1 into the facility on oxygen but did not connect him to oxygen when they transferred him to the bed in his room. She said LVN A said EMS left before CR #1 was stable, but LVN A got him up to 95% oxygen saturation and he became more alert and ate lunch. She said LVN A contacted CR #1's doctor because she verified his medications. She said as far as she knew, LVN A notified CR #1's doctor when he was in distress. She said it was the facility's protocol to notify a resident's doctor when they experienced a change of condition. She stated LVN A did not call her when CR #1 had low oxygen saturation when he was initially admitted . She said LVN A told her about the incident later that evening when CR #1 coded (experienced cardiac arrest). The DON stated she had the facility's on-call phone and LVN A did not call to notify of CR #1's change of condition. She stated LVN A should have followed protocol and notified her, as the DON when CR #1 had a change of condition. In a telephone interview with LVN A on [DATE], at 11:17 a.m., she stated on [DATE], EMS brought CR #1 to the facility between 12:15 p.m. and 12:30 p.m. without oxygen. She stated EMS was not very good because they left before making sure CR #1 was connected to oxygen. She said if she did not go into CR #1's room when she did, he would have died at that time because he was already in respiratory distress when she first observed him. She stated CR #1 arrived with his family and she told his family he did not look good. She said he asked CR #1's family to raise the head of the bed and she yelled for staff to bring an oxygen concentrator and oxygen tank because his oxygen saturation was assessed at 73%. She stated she immediately started CR #1 on 5L of oxygen until his oxygen saturation went up to ,d+[DATE]%. She said she then lowered the oxygen level to 3L. She said according to CR #1's family member, he was supposed to be on 2.5L of oxygen. She said after his oxygen saturation increased to ,d+[DATE]%, CR #1 started talking and ate lunch around 1:00 p.m. She said after CR #1 was stable, she reconciled his medications (the process of comparing a patient's medication orders to all the medications that the patient has been taking) with his physician. She stated she mentioned to CR #1's physician that his oxygen saturation was a bit low because he was not on oxygen when he admitted . She said she told CR #1's physician she placed him on oxygen, and he was stable after administering 5L. She said she told the physician she lowered the oxygen to 3L after CR #1's saturation level was above 90%. She said if she was not able to get CR #1's oxygen saturation back up, she would have called 911. She said the next time she saw CR #1 was around dinnertime (4:00 p.m. - 5:00 p.m.) when she saw him through the doorway as she passed his room in the hallway. She said CR #1 did not appear to be in distress at that time. She said around 5:00 p.m. - 6:00 p.m., a therapist (OT) was on the hall checking on new residents and the OT asked a CNA (she did not recall the name of the CNA) for a nurse. She said the CNA came up to her looking anxious and said CR #1 was unresponsive. LVN A said the OT said CR #1 did not look good and he was unresponsive, so she screamed for a code blue and requested a crash cart. She said she also yelled for someone to call 911. She said they initiated CPR until EMS arrived and took over, but CR #1 did not make it. She stated she was not able to keep up with CR #1 or get more familiar with him because she was so busy doing her other nursing duties on [DATE]. She stated the facility did not have any protocols or action plan regarding frequent monitoring of residents who experienced a change of condition. She said maybe she should have checked on CR #1 every 30 minutes, but their protocol was to round every two hours. She stated she resigned the night of [DATE] and did not return to the facility because CR #1 should not have died and she thought there should have been more nurses assigned to her unit. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA C on [DATE], at 12:45 p.m., he stated he worked the 6:00 a.m. - 2:00 p.m. shift on [DATE] and he worked with LVN A when CR #1 was admitted to the facility that day. He said CR #1 was brought into the facility by EMS on a stretcher without oxygen. He said EMS brought in paperwork and LVN A started working with CR #1. He said CR #1 was breathing heavily when EMS brought him into the building. He said he did not recall hearing CR #1 talk. He said he did not recall CR #1's family members saying he needed oxygen, but LVN A put oxygen on him quickly. He said he did not know what happened after LVN A placed CR #1 on oxygen because it was close to the end of his shift. He said he did not see CR #1 again after he initially assisted with getting him into his room. In an interview with LVN D on [DATE], at 1:30 p.m., he stated if a resident was admitted in respiratory distress, the nursing protocol would be to send them back to the hospital. He said if they had to keep the resident, nurses should stabilize the resident with oxygen. He stated the nurse should call the resident's doctor for orders and let the DON and ADON know so they could tell them how to proceed. In an interview with the ADON on [DATE], at 2:15 p.m., she stated after LVN A stabilized CR #1 with oxygen on [DATE], she should have notified his physician of what happened and monitored him closely (checked on him more frequently). She stated she did not recall LVN A saying she notified CR #1's physician about his condition when he admitted to the facility and she did not think LVN A reported the incident to the proper chain of command (DON, ADON, and Administrator). She said as the ADON, she was not notified of the first distress incident until after CR #1 coded, which was not the proper chain of command. She stated she was scheduled to work from 8:40 p.m. that night ([DATE]) to 7:40 a.m. Monday ([DATE]), but she received a call from CNA E at 7:30 p.m. and heard the commotion in the background when CR #1 coded, so she rushed to the facility. She stated CR #1 had already been pronounced deceased by the time she arrived at 8:45 p.m. In an interview with the OT on [DATE], at 2:46 p.m., she stated she worked at the facility on [DATE]. She said she did occupational therapy evaluations that day because the regular occupational therapist was unavailable. She said CR #1 was the last evaluation of the day since he was on isolation for COVID and C-diff. She said when she entered CR #1's room around 7:00 p.m. on [DATE], he looked like he was asleep. She said his arm was hanging off the bed, so she went to reposition him and wake him up. She said when CR #1 did not wake up, she did a sternal rub (a painful stimulus used by EMS to assess a patient's neurological status and brain function) and noted he was unresponsive. She said she saw a CNA (she did not say the name of the CNA) and told her to get a nurse because CR #1 was unresponsive. She stated she could hear CR #1's concentrator running when she was inside of CR #1's room. In a follow-up telephone interview with the OT on [DATE], at 8:19 a.m., she stated when she entered CR #1's room on [DATE], around 7:00 p.m., she observed that CR #1's nasal cannula was not in his nose. She said although she heard the oxygen concentrator running when she was inside the room, she did not see that nasal cannula anywhere. She stated she when she tried to reposition CR #1's head and performed the sternal rub, she did not see the nasal cannula. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with CR #1's physician on [DATE], at 3:10 p.m., he stated on [DATE], LVN A sent him a text with CR #1's medication list and diagnoses. He said LVN A indicated CR #1 was a transfer from a rehabilitation hospital and asked him to review his medications. He said he texted LVN A back that they would continue with the medication list received from the previous facility and he would visit the resident on Monday, [DATE]. He said that text conversation was earlier in the day on [DATE] and he did not hear anything else about CR #1 until later that night when LVN A called him after CR #1 died . He said at that time (during the phone conversation on the night of [DATE]), LVN A told him CR #1 had been unstable and in respiratory distress earlier in the day. He said he asked LVN A why she called him at 9:00 p.m. when everything was done instead of calling him earlier when CR #1 was unstable. He said LVN A told him she did not call earlier because CR #1 was more stable after she administered oxygen. He said LVN A never called him earlier on [DATE] to inform him that CR #1 was in respiratory distress, and she did not say he had an oxygen saturation of 73%, or that he required oxygen administration. He said if LVN A would have called him earlier when CR #1 was in distress, he would have asked her to repeat the oxygen assessment because sometimes, the measurements were not accurate. He said CR #1's oxygen saturation was too low but sending him to the hospital immediately would have depended on her ability to stabilize him with oxygen. He said LVN A told him she gave CR #1 2L or 5L of oxygen, then his saturation went up to ,d+[DATE]%. He said he would have told LVN A to monitor CR #1 closely (checked on him frequently) throughout her shift and if he became unstable, at any time, send him to the ER. He said the staff would have needed to monitor CR #1 often enough to make sure he did not crash (deteriorate quickly) and to ensure they could send him to the ER as soon as possible if he became unstable again. He said LVN A knew how to contact him. He said the facility's nurses were usually very good about calling him for guidance when they were concerned about a resident's condition. He said he expected the nurses to call him when his patients experienced a change of condition. In a telephone interview with CNA B on [DATE], at 11:20 a.m., she stated she worked the 2:00 p.m. - 10:00 p. m. shift on Sunday, [DATE]. She stated when she arrived for her shift around 2:00 p.m. - 2:15 p.m., LVN A told her CR #1 was just admitted and that he was not feeling well. She said LVN A told her CR #1 was admitted with a low oxygen saturation. She said after that, she introduced herself to CR #1. She said at that time, CR #1 had on a nasal cannula with oxygen running and he was fine. She said she checked on CR #1 again at 3:00 p.m. and he was asleep, breathing heavily, shaking, and talking in his sleep, like he was having a bad dream. She said she woke CR #1 up and asked him if he had a bad dream and he said he was ok. She said she dropped off CR #1's dinner tray around 4:00 p.m. She said CR #1's breathing was fine at first, but after a few minutes, he started breathing heavily, like how it would sound if someone went up a flight of stairs. She said she picked up CR #1's dinner tray between 5:00 p.m. and 5:25 p.m. and emptied his catheter bag. She said his nasal cannula was off his nose and he was breathing heavily, so she replaced the nasal cannula, and his breathing was fine after a minute. She said she never notified LVN A or any other nurse when she observed CR #1 breathing abnormally or when she found his nasal cannula out of place because LVN A already knew he was having trouble breathing. CNA B said LVN A told her he was having trouble when she initially reported to her shift. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow-up telephone interview with LVN A on [DATE], at 11:37 a.m., she stated it took about ten minutes for CR #1's oxygen saturation to go from 73% to 93% once she placed him on 5L of oxygen. She said once CR #1 was stable, she sent CR #1's doctor a text about his medications. She stated she did not mention CR #1's respiratory distress to the doctor because he was stable at that time, and she continued to administer 3L of oxygen. She said she did not see any notes in the computer system about CR #1 requiring oxygen therapy. She said CNA B never told her she observed CR #1 breathing heavily or that his nasal cannula fell off throughout the day. She said that information was big, and she would not have ignored it. She said had CNA B told her that information, she would have assessed him immediately. In an interview with the DON and Administrator on [DATE], at 12:39 p.m., the Administrator stated he did not think CR #1 was in distress when he arrived at the facility on [DATE] because LVN A usually contacted the DON and physicians with any concern she had about residents. The DON stated LVN A was disgruntled, and she thought LVN A lied about assessing CR #1's oxygen saturation at 73%. The Administrator said he did not think the incident was a system failure and LVN A was just having a bad day. The DON said LVN A did not document the progress note in real time. The DON said after CR #1 died , LVN A said she was quitting and the ADON told her to document before she left. The DON said LVN A documented the progress not around 9:00 p.m. and she doubted CR #1's oxygen saturation was that low. Record review of the facility's policy titled Change in a Resident's Condition or Status revised February 2021 revealed, Policy Statement. Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation. 1. The nurse will notify the resident's attending physician or physician on-call when there has been a(an): a. accident or incident involving the resident; . d. significant change in the resident's physical/emotional/mental condition; . need to alter the resident's medical treatment significantly; . 2. A 'significant change' of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self-limiting'); . 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. Record review of the facility's document titled Job Description: Charge Nurse dated [DATE] and signed by LVN A on [DATE] revealed, . Essential Duties: Make rounds and provide report . Respond to and monitor care issues and changes in condition . Communicate with physicians and other health professionals regarding resident care, treatment, and condition . Report significant findings or changes in condition and potential concerns to the Director of Nursing . Record review of the facility's document titled, Care Path - Symptoms of Shortness of Breath dated 2014 revealed the box which read, Symptoms of Shortness of Breath: Difficult or labored breathing that is out of proportion to the resident's level of physical activity; New complaint of SOB had an arrow which pointed to the box which read, Take Vital Signs: . Oxygen saturation . The next box reflected, Vital Sign Criteria (any met?): . Oxygen saturation less than 90%, and had an arrow which pointed to Yes; Notify MD/NP/PA. An IJ was identified on [DATE]. The IJ template was provided to the DON on [DATE] at 10:30 a.m. and a POR was requested. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* DON, and/or ADON/weekend supervisor will perform daily rounds on residents with changes of condition x 72 hrs and notify MD if needed for 4 weeks. * If/when discrepancies are identified, they will be corrected immediately. * Findings and trends will be reported to QAPI Committee monthly. * All nursing Staff notified that they will not work a shift until training is completed. Monitoring of the plan of removal included the following: Record review of an In-Service Training Report dated [DATE] revealed all nursing staff (nurses, CNA's and medication aides) were educated by the DON regarding making frequent rounds of all residents, especially on new admissions and residents with a change of condition. Record review of an In-Service Training Report dated [DATE] revealed all nursing staff were educated by the DON regarding notification to the DON, ADON, RN Supervisor, or the Administrator if they were not able to make frequent rounds on their assigned residents. The staff were also educated on the use of MD/NP notification manuals and location of the manual. Record review of an In-Service Training Report dated [DATE] revealed all nursing staff were educated by the DON regarding notifying physicians and nurse practitioners of clinical issues. The document reflected in part, Notify MD/NP of baseline vs upon admission of any concerns. Notify MD/NP of any SPO2 less than 90% and document any new orders and interventions. Monitor any residents closely exhibiting signs and symptoms of respiratory distress. Notify MD/NP and send to ER if ordered/indicated. Record review of an In-Service Training Report dated [DATE] revealed the Weekend Supervisor was educated by the DON regarding performance of daily rounds, ensuring nursing staff is also making frequent rounds, and conducting assessments on new admissions and any resident with a change in condition for 72 hours. Record review of the In-Service Training Report dated [DATE] revealed all nursing staff were educated by the DON regarding admission/re-admission assessments, follow-ups and notifications to the MD/NP and administrator, assessments of residents upon arrival to the facility and notifying the MD/NP of any concerns immediately and notifying MD/NP and nurse management of any changes in condition. The nurses were advised not to accept new admissions unless they were medically stable. Record review of a facility document titled In-Service Topic dated [DATE] revealed all therapy staff (physical therapy/occupational therapy/speech therapy) were educated by the SLP regarding steps to take when a change of condition is observed and the importance of documentation. Record review of a facility document titled Compliance Documents dated [DATE] revealed the Medical Director reviewed and agreed with the facility's current standing physician's orders and care paths. (continued on next page)

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	676434	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of the facility's policy titled Guidelines for Notifying Physicians of Clinical Problems revised February 2014 revealed, Overview. These guidelines are to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record . The charge nurse or supervisor should contact the attending physician at any time if they feel a clinical situation requires immediate discussion and management . Immediate Notification (Acute) Problems. The following symptoms, signs, and laboratory values (which are not inclusive) should be prompt immediate notification of the physician, after an appropriate nursing evaluation. Immediate implies that the physician should be notified as soon as possible, either by phone, pager, text message, or other means. These situations include: 1. Witnessed cardiac or respiratory arrest for individuals who have full code status. 2. Rapid decline or continued instability (for example, markedly fluctuating vital signs), unless the individual is receiving only palliative care. 3. The following symptoms: a. Sudden in onset or marked change compared to usual (baseline) status; and are b. Unrelieved by measures which have already been prescribed. 4. The following signs: . h. Tachypnea (rapid and shallow breathing) and dyspnea (shortness of breath) with a pulse oximetry below 90% . Observation of two nurse's station on [DATE] at 12:20 p.m. revealed each had a Notification Manual which contained each physician's contact information and a Provider's Standing Orders Manual which contained each physician's standing orders. Interviews were conducted on [DATE] from 11:30 a.m. until 4:20 p.m. with staff on all shifts (6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m.) including the Administrator, DON, MDS Coordinator, LVN M (Saturdays and Sundays morning and afternoon shifts), CNA AA (morning shift), LVN H (morning shift), CNA I (morning shift), CNA J (evening shift), CNA K (evening shift), LVN L (evening shift), Med Aide M (evening shift), LVN N (evening shift), LVN O (night shift), LVN P (night shift), CNA Q (night shift), and CNA R (night shift) to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding understanding of requirements, training material and expectations. The Administrator, DON, MDS Coordinator, LVN M, CNA AA, LVN H, CNA I, CNA J, CNA K, LVN L, Med Aide M, LVN N, LVN O, LVN P, CNA Q, and CNA R were able to explain the admission/readmission process related to initial assessments and communication/notifying nurse management and the physician of the resident's initial baseline and any changes of condition, the importance and location of the Notification Manual (the manual which contains each physician's contact information located at each nurse's station), the importance and location of each physician's standing orders manual (the manual which contains each physician's standing orders [written protocols that outline the circumstances in which certain members of the healthcare team can perform clinical tasks without a physician's order] located at each nurse's station), notifying physician if a resident's oxygen saturation is below 90%, oxygen administration and frequent [TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 10 residents (CR #1) reviewed for quality of care. LVN A accepted and retained a new admission from a rehabilitation hospital, CR #1, who was actively in respiratory distress with an oxygen saturation of 73% on [DATE], at approximately 12:30 p.m. and failed to monitor and assess him frequently throughout the rest of her shift (6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m.) after she administered 5L of oxygen and assumed his condition was stable. This failure resulted in LVN A being unaware of CR #1's continued respiratory distress until he was found unresponsive between 6:00 p.m. and 7:00 p.m. and subsequently expired. CNA B failed to inform LVN A or any nursing staff of CR #1's need for nursing assessment when she observed him with shortness of breath multiple times during her shift (2:00 p.m. - 10:00 p.m.) on [DATE] even though she was aware he previously experienced respiratory distress and required clinical interventions earlier in the day. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 10:30 a.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on [DATE]. These failures placed residents who experience a change of condition at risk of further deterioration and death. Findings include: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's face sheet dated [DATE] revealed he was a [AGE] year-old male who was admitted to the facility from a rehabilitation hospital on [DATE]. He was diagnosed with chronic congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), atherosclerotic heart disease (damage or disease in the heart's major blood vessels which causes the buildup of plaque), diabetes (a group of diseases that result in too much sugar in the blood) with polyneuropathy (damage or disease affecting peripheral nerves in roughly the same areas on both sides of the body which causes weakness, numbness, and burning pain), chronic kidney disease, stage 3 (when the kidneys have mild to moderate damage and are less able to filter waste and fluid from the blood), venous insufficiency (improper functioning of the vein valves in the leg which causes swelling and skin changes), enterocolitis due to recurrent clostridium difficile (inflammation of the colon and large intestine caused by bacteria), cardiac arrest (sudden, unexpected loss of heart function, breathing, and consciousness), essential hypertension (a form of hypertension [a condition in which the force of the blood against the artery walls is too high]without an identifiable physiologic cause), transient cerebral ischemic attack (a brief stroke -like attack that resolves within minutes to hours), sepsis (a life-threatening complication of an infection), acute respiratory failure with hypoxia (a medical emergency that occurs when the body does not have enough oxygen in its tissues and causes shortness of breath, confusion, cardiac dysfunction, and cardiac arrest), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). He was discharged from the facility on [DATE]. Record review of CR #1's entry MDS dated [DATE] revealed it only contained his personal information, such as his date of birth, marital status, insurance information, and date of admission. Record review of CR #1's electronic clinical record revealed no documentation of a care plan. Record review of CR #1's physician's orders revealed he was not prescribed scheduled or PRN oxygen therapy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's clinical records from the rehabilitation hospital dated [DATE] revealed he was admitted to the rehabilitation hospital from an acute care hospital on [DATE], and he was discharged to the facility on [DATE]. The document read, . History: This patient is a [AGE] year-old male who lived with a family member, previously independent. He has had multiple hospitalization s over the last several months, he had been here twice before. The first time was for recovery from total hip replacement, but he was transferred out acutely for change in his overall status and patient developed C. diff and a right lower extremity wound, which he currently has a wound vacuum. The patient was discharged home with family, but readmitted to acute care on [DATE] with complaints of diarrhea . He was admitted and followed for relapse of C. diff colitis . He was also followed for acute on chronic renal failure. No other major medical complications, but he remains quite weak . He has an indwelling catheter . [DATE], Cardiology Progress Note. Subjective: Patient seen and examined in the room, denies chest pain, no shortness of breath, no palpitations (feelings of fast-beating, fluttering, or pounding heart), no dizziness or syncope (fainting, or sudden temporary loss of consciousness), no orthopnea (discomfort when breathing while lying down flat), no nausea, vomiting, or diarrhea . [DATE], at 9:37 a.m.: oxygen saturation 99% . [DATE], at 4:15 p.m.: oxygen saturation 95% . Respiratory: Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal . [DATE]: Remains on isolation protocol. Still gets drowsy, requires full oxygen support (no details provided) . [DATE], at 1:39 p.m. - Treatment Session Conclusion - Patient Status: Location - Transport: Left in room, call light within reach, bedside table within reach (Comment: catheter intact, 2L O2 via nasal cannula .) . Further review of CR #1's medical records revealed no other documentation of oxygen administration or physician's orders for oxygen therapy. Record review of CR #1's progress notes for [DATE] revealed: view draft (typed in red). Effective date: [DATE], 7:15 p.m. LVN A wrote, Note Text: 12:15 p.m.: CR #1 was a new admit who arrived via EMS. He was accompanied by [several family members]. Resident was transferred by EMS from stretcher to bed by EMS x 2 assist. EMS woman giving report stated that resident was on isolation for C-diff and may also have COVID. Initial assessment O2 saturation at ,d+[DATE]% (according to medicinenet.com, sustained blood oxygen levels below ,d+[DATE]% can be life-threatening and may lead to death if not addressed promptly) room air, ,d+[DATE] [blood pressure], 73 [pulse]. Writer immediately directed to staff to bring a tank of oxygen and a concentrator to room. This nurse informed family that their loved one did not look too good, and that his O2 was a concern. Writer initiated O2 on 5L and decreased. Resident O2 saturation was accomplished with a reading of ,d+[DATE]% on 3L. Resident became more aroused and verbal. He communicated with writer and said that he [would] like to be addressed by his first name. Throughout assessment, EMS had already left the building. They did not ensure that resident was connected to oxygen prior to leaving. During assessment, family remained at bedside and answered questions from this nurse . Resident was provided lunch, writer noted that resident had only eaten approximately 50%. Family member stated that CR #1 did not eat much. Last time writer saw CR #1 prior to him coding, was roughly ,d+[DATE] hours earlier at approximately ,d+[DATE] p.m. Resident was quietly watching television and did not appear to be in any distress. Bed semi-Fowler (a medical position where a patient lies on their back with their head and upper body raised at a ,d+[DATE]-degree angle on the bed). Breathing non-labored. Therapist notified this nurse that resident [was] non-responsive. Nurse immediately called a code blue before getting in room. Upon arrival in room, nurse noted resident non-responsive and initiated CPR. Two nurses and several staff in room and assisted nurse with CPR and AED. 911 notified. CPR continued until 911 arrived and took over. Family members arrived five minutes behind. Resident pronounced (CR #1's death was announced) at 7:35 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the DON on [DATE], at 9:45 a.m., she stated CR #1 was admitted to the facility on Sunday, [DATE] around 12:00 p.m. then coded and passed away around 6:00 p.m. that same day. She said, according to LVN A, CR #1 did not look well, and his oxygen saturation was in the lower 70's when EMS transferred him from the gurney (stretcher) to the bed. She said to her knowledge, EMS brought CR #1 into the facility on oxygen but did not connect him to oxygen when they transferred him to the bed in his room. She said LVN A said EMS left before CR #1 was stable, but LVN A got him up to 95% oxygen saturation and he became more alert and ate lunch. She stated LVN A did not call her when CR #1 had low oxygen saturation when he was initially admitted . She said LVN A told her about the incident later that evening when CR #1 coded (experienced cardiac arrest). The DON stated she had the facility's on-call phone and LVN A did not call to notify of CR #1's change of condition earlier in the day, but she was on the phone with LVN A during the time when CR #1 coded. She stated LVN A should have followed protocol and notified her, as the DON when CR #1 had a change of condition. In a telephone interview with LVN A on [DATE], at 11:17 a.m., she stated on [DATE], EMS brought CR #1 to the facility between 12:15 p.m. and 12:30 p.m. without oxygen. She stated the EMS were not very good because they left before making sure CR #1 was connected to oxygen. She said if she did not go into CR #1's room when she did, he would have died at that time because he was already in respiratory distress when she first observed him. She stated CR #1 arrived with his family and she told his family he did not look good. She said he asked CR #1's family to raise the head of the bed and she yelled for staff to bring an oxygen concentrator and oxygen tank because his oxygen saturation was assessed at 73%. She stated she immediately started CR #1 on 5L of oxygen until his oxygen saturation went up to ,d+[DATE]%. She said she then lowered the oxygen level to 3L. She said according to CR #1's family member, he was supposed to be on 2.5L of oxygen. She said after his oxygen saturation increased to ,d+[DATE]%, CR #1 started talking and ate lunch around 1:00 p.m. She said if she was not able to get CR #1's oxygen saturation back up, she would have called 911. She said the next time she saw CR #1 was around dinnertime (4:00 p.m. - 5:00 p.m.) when she saw him through the doorway as she passed his room in the hallway. She said CR #1 did not appear to be in distress at that time. She said around 5:00 p.m. - 6:00 p.m., a therapist (OT) was on the hall checking on new residents and the OT asked a CNA (she did not recall the name of the CNA) for a nurse. She said the CNA came up to her looking anxious and said CR #1 was unresponsive. LVN A said the OT said CR #1 did not look good and he was unresponsive, so she screamed for a code blue and requested a crash cart. She said she also yelled for someone to call 911. She said they initiated CPR until EMS arrived and took over, but CR #1 did not make it. She stated she was not able to keep up with CR #1 or get more familiar with him because she was so busy doing her other nursing duties on [DATE]. She stated she could not closely monitor new residents because she did not think there were enough nurses on the shift (LVN A worked double weekend shifts, from 6:00 a.m. - 2:00 p.m. and 2:00 p.m. until 10:00 p.m.). She stated the facility did not have any protocols or action plan regarding frequent monitoring of residents who experienced a change of condition. She said maybe she should have checked on CR #1 every 30 minutes, but their protocol was to round every two hours. She stated CR #1's family member told her he needed a C-Pap machine for sleep apnea (he did not have the machine yet). She stated she resigned the night of [DATE] and did not return to the facilitybecause CR #1 should not have died and she thought there should have been more nurses assigned to her unit. She said the ADON said if she (LVN A) saw that CR #1 was not looking good, she should have sent him out. LVN A said CR #1 was a high risk patient (he had multiple comorbidities) and probably should not have been at the facility to begin with because a nurse would not be with him all the time. She said if she did not have so much other stuff to do, she could have kept up with CR #1 more. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow-up interview with the DON on [DATE] at 11:30 a.m., she stated LVN A was not happy on [DATE] because she had to admit two residents that day, but there was a total of four nurses in the building. She said LVN A told her that she (LVN A) told CR #1's family and the EMS who brought him to the building on [DATE] that CR #1 did not look good. The DON said LVN A called CR #1's family member on the phone to verify (prove to the DON) that she told EMS CR #1 did not look good, but EMS did not try to take CR #1 out of the building. In an interview with CNA C on [DATE], at 12:45 p.m., he stated he worked the 6:00 a.m. - 2:00 p.m. shift on [DATE] and he worked with LVN A when CR #1 was admitted to the facility that day. He said CR #1 was brought into the facility by EMS on a stretcher without oxygen. He said EMS brought in paperwork and LVN A started working with CR #1. He said CR #1 was breathing heavily when EMS brought him into the building. He said he did not recall hearing CR #1 talk. He said he did not recall CR #1's family members saying he needed oxygen, but LVN A put oxygen on him quickly. He said he did not know what happened after LVN A placed CR #1 on oxygen because it was close to the end of his shift. He said he did not see CR #1 again after he initially assisted with getting him into his room. In an interview with LVN D on [DATE], at 1:30 p.m., he stated if a resident was admitted in respiratory distress, the nursing protocol would be to send them back to the hospital. He said if they had to keep the resident, nurses should stabilize the resident with oxygen. He stated the nurse should call the resident's doctor for orders and let the DON and ADON know so they could tell them how to proceed. He said if the resident was stabilized, he would monitor them and assess frequently, make sure they had oxygen, and ensure their saturation was stable. In an interview with the ADON on [DATE], at 2:15 p.m., she stated after LVN A stabilized CR #1 with oxygen on [DATE], she did not think LVN A reported the incident to the proper chain of command (DON, ADON, and Administrator). She said as the ADON, she was not notified of the first distress incident until after CR #1 coded, which was not proper chain of command. She stated she was scheduled to work from 8:40 p.m. that night ([DATE]) to 7:40 a.m. Monday ([DATE]), but she received a call from CNA E at 7:30 p.m. and heard the commotion in the background when CR #1 coded, so she rushed to the facility. She stated CR #1 had already been pronounced deceased by the time she arrived at 8:45 p.m. She said she told LVN A if she received a resident who looked like they were in distress, nurses had the authority to refuse the admission and send the resident back to the hospital. She stated if a resident looked unstable, nurses should either send them out 911 or refuse to accept the resident. She said since LVN A did accept CR #1, and was able to stabilize him with oxygen, she should have notified his doctor about what happened and monitored him closely (checked on him frequently). She stated LVN A resigned and left the facility around 12:30 a.m. on [DATE]. In an interview with the OT on [DATE], at 2:46 p.m., she stated she worked at the facility on [DATE]. She said she did occupational therapy evaluations that day because the regular occupational therapist was unavailable. She said CR #1 was the last evaluation of the day since he was on isolation for COVID and C-diff. She said when she entered CR #1's room around 7:00 p.m. on [DATE], he looked like he was asleep. She said his arm was hanging off the bed, so she went to reposition him and wake him up. She said when CR #1 did not wake up, she did a sternal rub (a painful stimulus used by EMS to assess a patient's neurological status and brain function) and noted he was unresponsive. She said she saw a CNA (she did not say the name of the CNA) and told her to get a nurse because CR #1 was unresponsive. She stated she could hear CR #1's concentrator running when she was inside of CR #1's room. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow-up telephone interview with the OT on [DATE], at 8:19 a.m., she stated when she entered CR #1's room on [DATE], around 7:00 p.m., she observed that CR #1's nasal cannula was not in his nose. She said although she heard the oxygen concentrator running when she was inside the room, she did not see that nasal cannula anywhere. She stated she when she tried to reposition CR #1's head and performed the sternal rub, she did not see the nasal cannula. In a telephone interview with CR #1's physician on [DATE], at 3:10 p.m., he stated on [DATE], LVN A sent him a text with CR #1's medication list and diagnoses. He said LVN A indicated CR #1 was a transfer from a rehabilitation hospital and asked him to review his medications. He said he texted LVN A back that they would continue with the medication list received from the previous facility and he would visit the resident on Monday, [DATE]. He said that text conversation was earlier in the day on [DATE] and he did not hear anything else about CR #1 until later that night when LVN A called him after CR #1 died . He said at that time (during the phone conversation on the night of [DATE]), LVN A told him CR #1 had been unstable and in respiratory distress earlier in the day. He said he asked LVN A why she called him at 9:00 p.m. when everything was done instead of calling him earlier when CR #1 was unstable. He said LVN A told him she did not call earlier because CR #1 was more stable after she administered oxygen. He said LVN A never called him earlier on [DATE] to inform him that CR #1 was in respiratory distress, and she did not say he had an oxygen saturation of 73%, or that he required oxygen administration. He said if LVN would have called him earlier when CR #1 was in distress, he would have asked her to repeat the oxygen assessment because sometimes, the measurements were not accurate. He said CR #1's oxygen saturation was too low but sending him to the hospital immediately would have depended on her ability to stabilize him with oxygen. He said LVN A told him she gave CR #1 2L or 5L of oxygen, then his saturation went up to ,d+[DATE]%. He said he would have told LVN A to monitor CR #1 closely (check on him frequently) throughout her shift and if he became unstable, at any time, send him to the ER. He said the staff would have needed to monitor CR #1 often enough to make sure he did not crash (deteriorate quickly) and to ensure they could send him to the ER as soon as possible if he became unstable again. He said LVN A knew how to contact him. He said the facility's nurses were usually very good about calling him for guidance when they were concerned about a resident's condition. He said he expected the nurses to call him when his patients experienced a change of condition. In an interview with the DON on [DATE], at 10:15 a.m., she stated an oxygen saturation of 73% was really low and LVN A should have sent CR #1 out and contacted his doctor. She stated the EMS should have taken CR #1's vital signs before they left him at the facility on [DATE]. She stated she thought CR #1 was on oxygen when EMS brought him into the building. In a telephone interview with a representative of the transportation service that picked CR #1 up from his previous facility and brought him to the facility (on [DATE]) on [DATE], at 10:55 a.m., they stated their company only transported patients from one place to another and did not assess vital signs or write reports about the transport. At that time, a request was made to speak with the EMS who transported CR #1 to the facility, but the representative suggested to speak with the company's manager. A voicemail message was left for the manager on [DATE] at 11:00 a.m. but the call was never returned. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with CNA B on [DATE], at 11:20 a.m., she stated she worked the 2:00 p.m. - 10:00 p. m. shift on Sunday, [DATE]. She stated when she arrived for her shift around 2:00 p.m. - 2:15 p.m., LVN A told her CR #1 was just admitted and that he was not feeling well. She said LVN A told her CR #1 was admitted with a low oxygen saturation. She said if it was her and a resident arrived with a low oxygen saturation, she would have to send the resident back because they did not know what would happen. She said after that, she introduced herself to CR #1. She said at that time, CR #1 had on a nasal cannula with oxygen running and he was fine. She said she checked on CR #1 again at 3:00 p.m. and he was asleep, breathing heavily, shaking, and talking in his sleep, like he was having a bad dream. She said she woke CR #1 up and asked him if he had a bad dream and he said he was ok. She said she dropped off CR #1's dinner tray around 4:00 p.m. She said CR #1's breathing was fine at first, but after a few minutes, he started breathing heavily, like how it would sound of someone went up a flight of stairs. She said she picked up CR #1's dinner tray between 5:00 p.m. and 5:25 p.m. and emptied his catheter bag. She said his nasal cannula was off his nose and he was breathing heavily, so she replaced the nasal cannula, and his breathing was fine after a minute. She said the resident across from CR #1's room had his call light on, so she went in and provided incontinent care for him. She said after she left that room, she saw the OT checking on residents. She said the OT put on PPE because CR #1 was on isolation. She said after about two seconds, the OT came out of CR #1's room and said he was unresponsive. She said she went to the nurse's station and notified LVN A that CR #1 was unresponsive. She said the nurse called a code blue and initiated CPR. She said eventually, EMS and police arrived. She said she told the police that CR #1 arrived with a low oxygen saturation and the police said that if he had a low oxygen saturation, the first thing she should have done was send him back to the hospital. She said she never notified LVN A or any other nurse when she observed CR #1 breathing abnormally or when she found his nasal cannula out of place because LVN A already knew he was having trouble breathing. CNA B said LVN A told her he was having trouble when she initially reported to her shift. In an interview with LVN F on [DATE], at 11:45 a.m., she stated she worked double shifts on the weekends and she was present on [DATE]. She said she was working on another hall when she heard the code blue for CR #1. She said she grabbed the crash cart and ran to CR #1's room. She said once she got to the room, she noted CR #1's body was flaccid (soft and hanging loosely) and he was very pale in color with no other discoloration. She stated she placed the AED pads on CR #1's chest and noted his skin was warm. She stated if a new admission arrived to the facility in noticeable respiratory distress, she would not accept the resident and would try to send him right back to the hospital. She stated that an oxygen saturation of 73% was very low and LVN A never asked her or the other nurses who were present on the shift for help. She said after CR #1 coded, she told LVN A she should have asked for help earlier in the day when he had low oxygen. She said she would have monitored CR #1 every 15 minutes once he was stable after being in distress. In a follow-up telephone interview with LVN A on [DATE], at 11:37 a.m., she stated it took about ten minutes for CR #1's oxygen saturation to go from 73% to 93% once she placed him on 5L of oxygen. She said once CR #1 was stable, she sent CR #1's doctor a text about his medications. She stated she did not mention CR #1's respiratory distress to the doctor because he was stable at that time, and she continued to administer 3L of oxygen. She said she did not see any notes in the computer system about CR #1 requiring oxygen therapy. She said CNA B never told her she observed CR #1 breathing heavily or that his nasal cannula fell off throughout the day. She said that information was big, and she would not have ignored it. She said had CNA B told her that information, she would have assessed him immediately. She said she knew she should not have taken that resident (CR #1). (continued on next page)

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	676434	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with CR #1's family member on [DATE], at 12:28 p.m., he stated on [DATE], CR #1 was brought into the facility on a stretcher. He stated the EMS person who brought CR #1 in had taken him off oxygen in the ambulance and left him in his room with no oxygen. He stated once CR #1 was in his bed, he started having trouble breathing and the nurse had to place him on a high level of oxygen. He said LVN A entered the room and noticed CR #1 had trouble breathing. He said LVN A left the room to find an oxygen concentrator, which took a while. He said LVN A told him EMS was supposed to leave CR #1 on an oxygen tank until the facility got him on one. He said LVN A told him if she could not get his oxygen saturation back up, she would have to send him to the hospital. He said CR #1 had an oxygen tank on the back of his wheelchair at his previous facility, but he was not aware that CR #1 really needed oxygen to that extent. He said the previous facility was treating CR #1 for C-diff and dehydration, but he suspected CR #1 had CHF (a chronic condition in which the heart does not pump blood as well as it should) because he was always very swollen, and his condition got worse. He said he and the rest of CR #1's family did not think he was ready to be discharged , so they were fighting to keep him in the rehabilitation hospital. He said they appealed CR #1's discharge from the hospital, but since his insurance days ran out, they were about to make the family pay out-of-pocket. He said the family went ahead and let CR #1 get transferred to the facility and the appeal for the rehabilitation hospital was approved two days after he died at the facility. He said the previous facility allowed CR #1 to use a C-Pap machine for a few days, but they took it back. He said CR #1 had an appointment scheduled to get his own machine. In an interview with the DON and Administrator on [DATE], at 12:39 p.m., the Administrator stated he did not thing CR #1 was in distress when he arrived at the facility on [DATE] because LVN A usually contacted the DON and physicians with any concern she had about residents. The DON stated LVN A was disgruntled, and she thought LVN A lied about assessing CR #1's oxygen saturation at 73%. The Administrator said he did not think the incident was a system failure and LVN A was just having a bad day. The DON said LVN A did not document the progress note in real time. The DON said after CR #1 died , LVN A said she was quitting and the ADON told her to document before she left. The DON said LVN A documented the progress not around 9:00 p.m. and she doubted CR #1's oxygen saturation was that low. Record review of the facility's policy titled Oxygen Administration dated [DATE] revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration . General Guidelines . b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head . Assessment. Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (blue tone to the skin). 2. Signs or symptoms of hypoxia (rapid breathing, rapid pulse rate, restlessness, confusion). 3. Signs or symptoms of oxygen toxicity (tracheal irritation, difficulty breathing, or slow, shallow rate of breathing) . 6. Arterial blood gases and oxygen saturation . Steps in Procedure . 13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. 14. Periodically re-check water level in humidifying jar . Reporting . 2. Report other information in accordance with facility policy and professional standards of practice. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's procedure titled, Admitting the Resident: Role of the Nursing Assistant dated [DATE] revealed, Purpose: The purposes of this procedure are to assist the resident to his/her room and to help alleviate concerns and answer questions that the resident and family may have . Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed . 3. Any observations made during the procedure. 4. The resident's vital signs . Reporting: 1. Notify the supervisor and the attending physician of any wounds that the resident may have that may need to be treated . 3. Report other information in accordance with facility policy and professional standards of practice. Record review of the facility's document titled Job Description: Charge Nurse dated [DATE] and signed by LVN A on [DATE] revealed, The basic purpose of the Charge Nurse position is to provide direct nursing care to the residents and to supervise the daily nursing activities performed by nursing personnel enlisted to your charge . Essential Duties: Assist residents in achieving the highest practicable level of self-care, independence, and well-being. Make rounds and provide report . Respond to and monitor care issues and changes in condition . Supervise, instruct, and assist nursing assistants in provision of care including prompt response to call lights . Communicate with physicians and other health professionals regarding resident care, treatment, and condition. Admit, discharge, and transfer residents according to the facility's policies and procedures . Report significant findings or changes in condition and potential concerns to the Director of Nursing . An IJ was identified on [DATE]. The IJ template was provided to the DON on [DATE] at 10:30 a.m. adn a POR was requested. The following Plan of Removal submitted by the facility was accepted on [DATE] at 11:50 a.m.: PLAN OF REMOVAL Name of Facility Date:___[DATE]_____ Date of compliance: [DATE] F684 Immediate action: * Resident CR#1 is no longer at the facility. * LVN A resigned and is no longer employed as off [DATE] * Nurse Management came in on [DATE] at 7p, to Assist Nurse and Monitor All Residents for Change in Condition and assist in Admission. * DON and ADON performed health checks on all Resident for Potential harm on [DATE]. Including but not limited to, pain, respiratory issues, general appearance, grievances and overall wellness- no harm found. If any Change in Condition noted would report to MD and Administrator. None noted. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* DON and designee in-service nurses on [DATE] to [DATE] regarding Admissions, Readmission assessments, change in condition and follow up, notifying the physician. Facilities Plan to ensure compliance quickly * DON and/or designee to in-service nurses on O2 administration and monitoring when resident is on respiratory distress. By [DATE] * DON and/or designee to In-service nurses on calling DON/ADON/Weekend supervisor and or administrator if the [TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40249 Based on observation, interview and record review, the facility failed to ensure that residents received the necessary treatment and services, to promote healing and prevent infection for 1 of 5 residents (Resident #2) reviewed for pressure ulcers in that: -Resident #2's posterior right knee Stage 3 and Sacrococcyx stage 4 dressings were not changed as per physician's orders on 8/17/24. -The Wound Care Nurse failed to transcribe the wound care doctor's order dated 8/13/24 for Resident #2. These failures could place residents with wounds or who are at risk of developing wounds placing them at risk of infection, a decline in health, pain, and hospitalization . Findings included: Record review of the admission sheet (undated) for Resident #2 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included sepsis (a life-threatening complication of an infection), pressure ulcer of sacral region, stage 4 (skin injuries that occur in the sacral region of the body, near the lower back and spine) and chronic kidney disease, stage 4 (longstanding disease of the kidneys leading to renal failure). Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS of 14 out of 15 indicating intact cognition. He was dependent on staff for toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene. Further review of section M0300 revealed Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers was coded 2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry was coded 2. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers was coded 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry was coded 2. Record review of Resident #2's Care plan initiated 01/22/2024 and revised on 8/13/24 revealed the following care plan: Focus: [Resident#2] admitted to facility with multiple pressure ulcer injuries Sacrum-Stage IV Lt Flank -Stage IV -resolved Lower Mid-back-Unstageable Lt lateral leg-Stage IV resolved 7/30/24 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lt Plantar Heel- DTI resolved Rt plantar heel-DTI resolved 8/13/24 Goal: [Resident#2] Pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions/Tasks: Monitor dressing to ensure it is intact and adhering. Report lose dressing to Treatment nurse. Record review of Resident#2's Surgical Note dated 08/13/24 revealed in part: . Reason for visit: To evaluate this patient for wounds located on the Sacro coccyx, right posterior knee, and right posterior heel. Change in patient health: No change since last visit. Location: Sacro coccyx. Etiology: Pressure injury/ulcer - Wound Stage: 4 - Pressure Injury. Dressing used: Betadine, Collagen and Dry dressing. Wound location: Right Posterior Knee. Etiology: Pressure injury/ulcer - Wound Stage: 3 - Pressure Injury. Dressing used: Betadine, Dry Dressing and Silvasorb gel . Record review of Resident #2's physician's order dated 06/21/2024 revealed an order for Wound Care: Posterior R Knee Pressure 3: Cleanse with ns/wc, pat dry, betadine periwound, collagen and hydro gel and cover with bordered gauze change every other day and prn. Record review of Resident #2's physician's order dated 06/21/2024 revealed an order Wound Care: Sacro Coccyx Pressure 4: cleanse with wc/ns, pat dry, apply betadine to periwound, hydrogel to wound bed, collagen particles, cover with dry dressing change every other day and prn. Observation on 08/17/2024 at 11:16a.m., revealed LVN Z providing wound care for Resident #2. LVN Z was assisted by CNA AA. LVN Z gathered the supplies at the treatment cart in the hallway before bringing them into Resident #2's room. Prior to initiation of the treatment, Resident #2 was assisted on to his left side. There was no dressing on the posterior right knee. Continued observation revealed an open area of approximately 0.4 centimeters in diameter. LVN A cleansed it with normal saline, removed his soiled gloves, and without sanitizing/washing his hands donned clean gloves. LVN Z patted dry the wound with dry gauze and applied betadine, collagen powder (not ordered) and hydro gel (not ordered) and covered the wound with a dry border dressing. LVN Z failed to apply Silvasorb gel as ordered by the physician. LVN Z removed the resident's soiled Sacro coccyx wound dressing dated 8/16/24 and placed it in the biohazard bag taped on the bedside table. Continued observation revealed an open area of approximately 6.0 centimeters in diameter. LVN Z cleansed the wound with normal saline x5. LVN Z said, The wound is bleeding. I am trying to apply pressure. LVN Z removed his soiled gloves, and without sanitizing/washing his hands donned clean gloves. LVN Z patted dry the wound with dry gauze and applied hydrogel (not ordered). LVN Z said, I need to get more gloves and removed his soiled gloves and left the room. LVN Z returned within few seconds and without sanitizing/washing his hands donned clean gloves. LVN Z applied collagen particles to the wound bed and covered it with a dry border dressing. LVN Z failed to use betadine as ordered by the physician. LVN Z left the room without washing/sanitizing his hands. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 08/17/24 at 11:42 a.m., the Surveyor reviewed Resident #2's physician orders with LVN Z. LVN Z said he started working in April 2024 as PRN at the facility on weekends. He said usually the Weekend Supervisor preformed wound care on the weekends. He said on the schedule he was assigned to work on the floor but was pulled to do wound care today (8/17/24). He said he did not receive training/competency check off on wound care at this facility at the time of hire. He said he could not recall receiving infection control and hand hygiene in-service at this facility. LVA Z said not performing hand hygiene while changing gloves could result in cross contamination. He said he did not have access to the wound care doctor's evaluations. He said he was following the wound care orders in the TAR. He said it was important to follow wound care doctor order for wound healing. In an interview on 08/17/24 at 11:54 p.m., with LVN N, she said she was assigned to work west hall which was long term. She said nobody had informed her that Resident #2's dressing was missing/dislodged. She said she did not have access to the WCD's evaluation. She said nurses followed treatment orders on the TAR. In an interview on 08/17/24 at 12:01 p.m., with the Weekend Supervisor, she said she started 3 weeks ago at this facility and was on orientation. She said the nurse who had the patient on the floor was responsible to do the treatments. She said, I have never been asked to do the wound care. I am not trained to do the wound care. In an interview on 08/17/24 at 12:12p.m. with the ADON, the Surveyor shared the wound care observation from earlier. The ADON said the WCN worked Monday through Friday and on the weekends LVN Z or LVN M performed the treatments. She said LVN Z followed the agency RN upon hire and was acquainted with facility/wound care. ADON said she could not recall the exact number of days he received orientation. ADON said, I am not specialized or certified in wound care, but [LVN Z] should have followed physician orders [the] WCD ordered betadine for a reason. ADON said CNAs should notify somebody either the floor nurse or WCN if they see a wound dressing missing. ADON said the floor nurse could apply the dressing by following the physician's orders in PCC (electronic medical records)., it's in their scope of practice to follow orders. ADON said the WCD rounded every Tuesday and the WCN had access to the WCD's notes. ADON said the WCN was responsible to review the WCD's wound evaluation/orders and transcribe them in PCC . In an interview and record review on 8/17/24 at 12:09p.m. with the Administrator, he said upon hire nurses received a Facility Assessment: Skin and Wound Care Readiness checklist and watched videos on wound care. He said he expected nurses to follow physician's orders. He said the risk of not following orders would be that the wounds could get worse. He said he did not have access to the WCD's recent notes/portal. He said he looked in PCC and could find WCD's notes dated 7/16/24. He said the WCN was out of state and was unable to access the WCD's portal. He said he had contacted the WCD to get his recent notes/orders from 8/13/24. Attempted telephone interview on 08/17/24 at 12:38p.m., with the Wound Care Nurse was unsuccessful. Attempted telephone interview on 08/17/24 at 1:22p.m., with the Wound Care Doctor was unsuccessful. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/17/24 1:42p.m., with CNA AA, she said she changed Resident#2 twice this morning, honestly I don't remember seeing if there was a dressing on his knee. In an interview on 08/17/24 1:52p.m., with LVN M, she said floor nurses were responsible to do their own treatments on the weekend if no one was assigned to do wound care on the schedule. She said she did not have access to the WCD's evaluation. She said nurses followed treatment orders on the TAR. Record review of Facility Assessment: Skin and Wound Care Readiness revealed in part: .The purpose of this assessment is to evaluate the necessary and available resources to provide wound care services to the residents in your facility. 3. Education/Training/Competencies: Wound Care Nurses: Wound care/Dressing/infection control, skin Assessments . Record review of facility's Wound Care (Revision date October 2010) revealed in part: .Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: I. Verify that there is a physician's order for this procedure. Steps in the Procedure: 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 .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40249 Based on observations, interviews, and record review the facility failed to establish and 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 infection for 1 of 4 residents (Resident #2) reviewed for infection. -The facility failed to ensure LVN Z performed hand hygiene during wound care on Resident #2. This failure could lead to the spread of infection to residents, resident illness, and/or resident distress. Findings included: Record review of the admission sheet (undated) for Resident #2 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included sepsis (a life-threatening complication of an infection), pressure ulcer of sacral region, stage 4 (skin injuries that occur in the sacral region of the body, near the lower back and spine) and chronic kidney disease, stage 4 (longstanding disease of the kidneys leading to renal failure). Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS of 14 out of 15 indicating intact cognition. He was dependent on staff for toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene. Further review of section M0300 revealed Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers was coded 2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry was coded 2. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers was coded 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry was coded 2. Record review of Resident #2's Care plan initiated 01/22/2024 and revised on 8/13/24 revealed the following care plan: Focus: [Resident#2] admitted to facility with multiple pressure ulcer injuries Sacrum-Stage IV Lt Flank -Stage IV -resolved Lower Mid-back-Unstageable Lt lateral leg-Stage IV resolved 7/30/24 Lt Plantar Heel- DTI resolved (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rt plantar heel-DTI resolved 8/13/24 Goal: [Resident#2] Pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions/Tasks: Monitor dressing to ensure it is intact and adhering. Report lose dressing to Treatment nurse. Record review of Resident #2's physician's order dated 06/21/2024 revealed an order for Wound Care: Posterior R Knee Pressure 3: Cleanse with ns/wc, pat dry, betadine periwound, collagen and hydro gel and cover with bordered gauze change every other day and prn. Record review of Resident #2's physician's order dated 06/21/2024 revealed an order Wound Care: Sacro Coccyx Pressure 4: cleanse with wc/ns, pat dry, apply betadine to periwound, hydrogel to wound bed, collagen particles, cover with dry dressing change every other day and prn. Observation on 08/17/2024 at 11:16a.m., revealed LVN Z providing wound care for Resident #2. LVN Z was assisted by CNA A. LVN Z gathered the supplies at the treatment cart in the hallway before bringing them into Resident #2's room. Prior to initiation of the treatment, Resident #2 was assisted on to his left side. There was no dressing on posterior right knee. Continued observation revealed an open area of approximately 0.4 centimeters in diameter. LVN A cleanse with normal saline, removed soiled gloves without sanitizing/washing his hands donned clean gloves, pat dry the wound with dry gauze. Applied betadine, collagen powder (not ordered) and hydro gel (not ordered) and covered it with dry border dressing. LVN Z failed to apply Silvasorb gel as ordered by the physician. LVN Z removed the resident's soiled Sacro coccyx wound dressing dated 8/16/24 and placed in the biohazard bag taped on the bedside table. Continued observation revealed an open area of approximately 6.0 centimeters in diameter. LVN Z cleansed the wound with normal saline x5. LVN Z said, the wound is bleeding. I am trying to apply pressure. LVN Z removed soiled gloves without sanitizing/washing his hands donned clean gloves, pat dry the wound with dry gauze. Applied hydrogel (not ordered). LVN Z said, I need to get more gloves removed soiled gloves and left the room. Returned in few seconds without sanitizing/washing his hands donned clean gloves, applied collagen particles to the wound bed and covered it with dry border dressing. LVN Z failed to use betadine as ordered by the physician. LVN Z left the room without washing/sanitizing his hands. In an interview and record review on 8/17/24 at 11:42 a.m., Surveyor reviewed Resident#2's physician orders with LVN Z. LVN Z said he started working in April 2024 as PRN at this facility on weekends. He said usually the Weekend Supervisor preformed wound care on the weekends. He said on the schedule he was assigned to work on the floor but was pulled to do wound care today (8/17/24). He said he did not receive training/competency check off on wound care at this facility at the time of hire. He said he could not recall receiving infection control and hand hygiene in service at this facility. LVA Z said not performing hand hygiene while changing gloves could result in cross contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676434	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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 8/17/24 at 12:12p.m. with the ADON, the Surveyor shared the wound care observation from earlier. The ADON said she was a certified infection preventionist. She said she in-serviced staff twice a month on infection control. She said LVN Z told her that, it slipped my mind to sanitize. The ADON said she expected staff to follow standard infection control techniques during the provision of wound care treatments. She said the staff were expected to move from the cleaner area of the wound to the possibly soiled or contaminated area of the body. ADON said LVN Z should have changed his gloves and performed hand hygiene moving from dirty to clean as it placed risk for infections. She said she would need to do counseling with him. Record review of facility's In-Service Training Report dated 8/8/24 conducted by ADON revealed in part: . Department(s): NSG, Employee group(s) present: NSG. Topic/Title: Hand Hygiene/infection control. Contents or summary of training session (if related to OSHA standard bloodborne pathogens training indicate See Below and use that convenient check-off list): Staff will know when hygiene is indicated and be able to demonstrate procedure per guidelines. The in-service was not signed by LVN Z. Record review of facility's Hand Washing/Hand Hygiene policy (Revised October 2023) revealed in part: . Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation Administrative Practices to Promote Hand Hygiene 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for Hand Hygiene g. immediately after glove removal . Record review of facility's Policies and Practices - Infection Control (Revised October 2018) revealed in part: . Policy Statement: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections .