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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676435	A. Building B. Wing	06/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Houston Transitional Care	8550 Jason Street Houston, TX 77074

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #41) reviewed for incontinent care. The facility failed to ensure Resident #41's foley bag was not place on the bed during wound care. This failure could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #41's face sheet dated 05/30/24 revealed a [AGE] year-old male was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #41 had diagnoses included: hypertension (blood pressure in the blood vessels is too high), cerebral infraction (damage to tissues in the brain due to loss of oxygen to the area), diabetes mellitus (a disease of inadequate control of blood levels of glucose), and atherosclerotic heart disease(thickening or hardening of the arteries). Record review of Resident#41's admission MDS assessment dated [DATE] revealed: Resident #41 had BIMS of 12 out of 15 indicated moderate impaired cognition. Further review revealed Resident #41 had an indwelling foley catheter. Record review of Resident #41's care plan dated 03/2724 revealed Resident #41 has foley catheter. Interventions: Monitor/record/report to MD for s/sx UTI: pain, burning, blood-tinged urine, Record review of Resident #41's physician order dated May 2024 read in part . Indwelling catheter DX: urine retention, Monitor for S/S of Infection, initiated on 03/08/24 . During an observation on 05/29/24 at 2:17 p.m., the wound care nurse placed Resident #41's Foley bag on the bed from 2:18 p.m. to 2:28 p.m. during wound care, and the urine backed up into the Foley tube. (continued on next page)

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

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/24 at 2:42 p.m., the Wound care nurse said she placed Resident #41's Foley bag on the bed, and it was at the same leave as the bladder. The wound care nurse said the Foley bag should be placed below the bladder for the urine to drain by gravity. The wound care nurse said Resident #41 could have a UTI if the urine flowed back into his bladder. The wound care nurse said she had in service on Foley care, and the DON and ADON monitored the nurses to ensure they were providing care appropriately when they made random checks. During an interview on 05/30/24 at 1:52 p.m., the DON said placing Resident #41's Foley bag on the bed could have caused pressure, urine flow backward, and infection. The DON said the Foley bag should always be below the Resident's bladder. The DON said she and the ADON monitored the nurses when they make random rounds and talk to the residents about care. Record review of the facility policy on catheter care urinary dated 2001 MED - PASS, Inc. read in part . The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections . Maintaining Unobstructed Urine Flow .#3 Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care and services, including oxygen administration was provided such care, consistent with professional standards of practice for 2 of 4 residents (Resident #10 and #11) reviewed for respiratory therapy in that: The facility failed to ensure Resident #10 and Resident 11's oxygen was set according to physician orders. This failure could place residents at risk of respiratory distress. The findings were: 1. Record review of Resident #10's face sheet dated 05/30/24 revealed an [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #10 had diagnoses included: respiratory failure (a serious condition that makes it difficult to breathe on your own) and chronic obstructive pulmonary disease (a long - term lung disease that makes it hard to breath. Record review of Resident #10's quarterly MDS assessment dated [DATE] revealed: Resident #10 had BIMS 12 indicated moderately impaired cognition. Further review revealed it was not indicated Resident #10 was on oxygen. Record review of Resident #10's care plan dated 01/29/24 revealed the resident was on oxygen. Intervention: monitor and report signs of hypoxia (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse) to physician Record review of Resident #10 physician order dated May 2024 read in part . O2 @2-3LPM via nasal cannula continuous per concentrator every shift ordered date 5/29/2024 . During an observation on 05/29/24 at 9:20 a.m., it was revealed that Resident #10's oxygen concentrator was set on 4L. Resident #10 did not respond when asked if she knew where the oxygen should be set on the concentrator. During an interview on 05/29/24 at 11:28 a.m., LVN M said he had not checked Resident #10's oxygen setting since he came to work today and needed to know how many liters of oxygen Resident #10 should be on. LVN M said he would guess 2 to 3 Liters because that was what most residents ordered for oxygen. LVN M stated that you must get an order from the physician to increase or decrease the oxygen setting. LVN M said if Resident #10 was having any crisis, the nurse could increase or decrease the oxygen, notify the doctor, and follow the doctor's order. LVN M said the night nurse did not tell him Resident #10 had any crisis or emergency with regrade to respiration. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24 at 1:31 p.m., the DON said LVN M should have checked Resident #10's order to make sure the O2 was set as ordered, and it was the same negative outcome for the resident as the previous resident. The DON said the ADON, ADON, NP, or the doctors monitor the nurses. The DON said they monitor the nurses by checking the EMAR and ETAR to see if the nurses have signed off, and each department head checks on the residents. During an interview on 05/31/24 at 3:40 p.m., the ADON said her expectation was for LVN M was to check Resident #10 oxygen setting upon coming to the shift and check on the setting sparingly through his shift. The ADON said that for Resident #10 to be on oxygen, the resident should have a physician's order and that the setting on the concentrator should match the order. The ADON said it depended on what Resident #10 diagnoses were, and if Resident #10 got more oxygen than required, Resident #10 could have a negative outcome. The ADON did not respond on what type of outcomes. The ADON said the nurse must have a physician order to increase or decrease the oxygen setting. The ADON said the facility had a respiratory therapist who came and educated the nurses, and the DON, ADON, monitored the nurses. 2. Record review of Resident 11's face sheet dated on 05/31/24 revealed a [AGE] year old male was administered to the facility on [DATE]. Resident #11 Resident #11 had diagnoses included: dyspnea(shortness of breath), and chronic obstructive pulmonary disease(a long - term lung disease that makes it hard to breath). Record review of Resident #11's admission MDS dated [DATE] revealed: Resident #11 had a BIMS of 15 which indicated intact cognition. Further review revealed Resident #11 was on oxygen therapy. Record review of Resident 11s care plan dated 03/28/24 read Oxygen: Resident requires the use of oxygen related to chronic obstructive pulmonary disease. Intervention: educate the resident on the importance of keeping oxygen on and at the prescribed setting. O2 @_3_LPM via nasal cannula continuous per concentrator. Record review of Resident 11's physician's order dated May 2024 read in part . O2 @3-4LPM via nasal cannula continuous per concentrator every shift ordered date 5/31/2024 . During an observation on 05/29/24 at 9:46 a.m., Resident #11's oxygen was set at 6 liters on the concentrator. Resident #11 could not verbalize where the oxygen was supposed to be set. During an interview on 05/29/24 at 11:16 a.m., LVN M said the oxygen was set at 6 Liters on the concentrator, but Resident #11's 02 should be set between 3 and 4. LVN M said Resident #11 should have an order if the oxygen would be higher than the previous order. LVN M said Resident #11's friend usually changes the setting, and everybody was aware of it. LVN M said Resident #11 could have a negative out when given more oxygen than ordered. LVN M said he did not report to the DON; he just told the hospice nurse that Resident #11's friend increased the setting on the concentrator. LVN M said the nurse he took over from today did not give him any report that Resident #11 had any issue that would warrant the oxygen to be increased. LVN M said he had not checked Resident #11's oxygen setting since he came to work today and would check the oxygen setting whenever he got to the resident's room because he was the only nurse for 35 residents. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24 at 1:16 p.m., the DON said for Resident #11 to be on oxygen, Resident 11 must have a doctor's order, and when the setting was increased or decreased, the doctor must give an order. The DON said LVN M should know, and the nurse should fix the setting on the concentrator according to the order. The DON said LVN M should make rounds every two hours to check on residents with oxygen and ensure oxygen was in the correct setting. The DON said if Resident #11 had an emergency, the nurse could change the setting to stabilize the resident, and the doctor would be notified as soon as the resident was stabilized and followed the physician's order. The DON said that depending on Resident #11's diagnosis, the resident's health could worsen if the oxygen was set above or below the resident's order. The DON said Resident #11's physician knew the family's increasing O2. The DON said he had to check the physician's statement and get back to the surveyor. Record review of the facility policy on oxygen administration dated 2001 MED - PASS, Inc. revision date October 2010 read in part . The purpose of this procedure is to provide guidelines for safe oxygen administration . Preparation . 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs to meet the needs for 1 of 9 Residents (#36) reviewed for pharmacy services in that: Register Nurse (RN) A failed to follow medication administration policies resulting in Licensed Vocational Nurse (LVN) A attempting to give Resident #36 a double dose of resident's 8:00 a.m. prescribed medications. RN A failed to document the start date for Resident #36's medications. Failures could place all residents at risk of drug diversion, health decline, and/or death. Findings included: Record review of the Face Sheet for Resident #36 reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: end stage renal disease, dependence on renal dialysis, atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, with a primary diagnosis of hypertension. Record review of Resident #36 Minimum Data Set (MDS) assessment, dated 03/08/2024, reflected a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intake. Record review of Resident #36's Care Plan with a printed date of 05/31/2024, reflected the following: Focus: Cardiac: Resident is at risk for cardiac issues related to atrial fibrillation, coronary artery disease, hypertension Date Initiated: 12/10/2022 Revision on: 3/29/2023. Goals: Resident will be compliant with medication regimen for cardiac health issues through next review Date Initiated: 12/10/2022 Revision on: 01/29/2024 Target Date: 06/26/2024. Resident will not have any symptoms of cardiac distress through next review Date Initiated: 12/10/2022 Revision on: 01/29/2024 Target Date: 06/26/2024. Resident will have blood pressures within the following parameters through next review Date Initiated: 12/10/2022 Revision on: 01/29/2024 Target Date: 06/26/2024. Interventions/Tasks: Monitor vital signs as indicated and Notify Medical Doctor (MD) as needed Date Initiated: 12/10/2022. Notify MD of symptoms of cardiac distress such as chest pain; irregular heart rate; fainting; numbness; pain or tingling in extremities, neck, or upper back; cold sweats; dizziness; increased or decreased blood pressure Date Initiated: 12/10/2022. Observe for edema, weight gain, and adventitious lungs sounds and report to MD when needed date Initiated: 12/10/2022. Observe for side effects or cardiac medications Date Initiated: 12/10/2022. Record review of Resident #36's electronic medication administration record (EMAR) dated 05/31/2024 reflected LVN A administered the following 8:00 a.m. medications: Amlodipine Besylate Oral Tablet 5 MG for high blood pressure. Do not give if systolic is < 120 diastolic <60. Blood Pressure (bp,): Finasteride Tablet 5 MG for benign prostatic hypertrophy (BPH). Lidoderm External Patch 5 % to relieve the pain. Sertraline HCL tablet 50 mg for depression. Amiodarone HCL tablet 200 mg for arrythmia. Apixaban tablet 5 mg for blood clot prevention. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #36's EMAR creation date 05/31/2024 at 02:11 p.m. reflected Captopril Tablet 25 MG Give 12.5 mg by mouth every 24 hours as needed for elevated bp greater than 170 PRN Administration was: Ineffective. Author RN A. Interview on 05/31/2024 at 10:39 AM Resident #36 stated he had a dialysis chair time of just 6 a.m. on 05/31/2024. He stated just before going to dialysis, RN A gave him his morning meds. He stated around 8:00 a.m., while still in dialysis LVN A attempted to pass him his morning meds again. He stated he denied the meds informing LVN A he had already received them. He stated he feared had he not been alert; he would have received a double dose of medications. Interview on 05/31/2024 at 11:46 a.m. LVN A stated she had been a nurse with the facility for 3-years. She stated that on 05/31/2024 her shift began at 6:00 a.m. but she arrived at 6:30 a.m. and began passing meds. She stated at about 7:00 a.m. she entered the dialysis room and recorded Resident #36's bp from the dialysis machine he was hooked up to and asked resident had he gotten his morning meds. She stated Resident #36 told her he had received his meds from RN A. She stated that the eMAR reflected that Resident #36 had not received his meds. She then signed off on Resident #36's meds. She stated that had not happened before. She stated because she late, RN A covered for her morning med passes until she arrived. Interview on 05/31/2024 at 11:58 a.m. the DON stated that he was not aware that LVN A had signed off on meds administered by RN A. The DON stated the staff that administers medication should be the staff who signed off on medications, to ensure it was giving and to follow the 6th rights of the medication. The DON stated the medication policy stated that meds were to be given 45 minutes before dialysis begins unless it was a bp medication. He stated the EMAR would not allow staff to sign-off on medications passes without adding a resident's bp. He stated Resident #36's bp fluctuates and was often very high and that was the reason resident received his medication prior to dialysis. He stated medication can be passed to dialysis residents before, during or after dialysis and could be nursing judgement. He stated he would check the actual time Resident #36 received dialysis and provide documentation. Interview on 05/31/2024 at 01:35 p.m. the MD stated that because Resident #36's bp runs high it was fine to administer his bp medication prior to dialysis. He stated that enough of the medication would be absorbed to benefit the resident. He stated the resident's medication doses were adjusted to compensate for the dialysis treatments. Interview on 05/31/2024 at 03:17 p.m. Resident #36 stated that most often he takes his morning meds before dialysis. He stated if his bp was below 125, he would hold all meds until after dialysis and if it was higher than 125, he would take all meds. He stated his chair time was at 6am. He stated that the staff get him up in the morning sometime around 5:00 a.m. and to dialysis at 5:30 a.m. Interview on 05/31/2024 at 3:37 p.m. the DON stated that Resident #36 was given his bp meds around 5:00 a.m. on 05/31/2024 just before dialysis because the resident's bp was high. He stated that the resident has a PRN of captopril every shift and as needed. He stated RN A should have informed MD that the resident's bp was high and if the medication did not work, and a progress note was made by RN A 05/31/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/31/2024 at 11:06 p.m. RN A stated he had worked at the facility nearly 2-years. He stated that Resident #36 had a 6:00 a.m. dialysis chair time on 05/31/2024. He stated took resident's vitals at 5/5:06 a.m. and resident's bp was 172/80. He stated that resident had a prescription for captopril 12 mgs to be administered prn. He stated that he took the vitals again and after 6am and it was 159/75 and since it was still high, he called the MD who told him to administer all the resident's morning meds. He stated he administered the meds that were normally assigned for the LVN A to administer: He stated he was rushing off shift and forgot to sign off on administering Resident #36' meds or complete the progress note regarding the MD's order to administer the prn medication. He stated the importance of checking off on administering resident's medications was to ensure that the residents do not receive double doses He stated it was all on him that the meds were not signed off and notes not entered regarding the MD's instructions. He stated had an in-service on med administration about 2-weeks ago. Record review of policy Medication Administration Schedule with a revised date of November 2020 reflected: Scheduled medications are administered within one (1) hour of their prescribed time, unless otherwise specified. Record review of policy Medication and Treatment Orders with a revised date of July 2016 reflected: Policy Statement Orders for medications and treatments will be consistent with principles of safe and effective order writing. Policy Interpretation and Implementation 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date, and the time of the order.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 44669 Based on observation, interview and record review, the facility must dispose of garbage and refuse properly for 1 of 1 dumpster reviewed for garbage disposal. -The facility failed to ensure the dumpster door was secured. This failure could place all residents at risk of infections, pests, and rodents from improperly disposed garbage. Findings included: Observation and interview on 05-29-2024 at 8:21 am, revealed the facility's commercial size dumpster 1/4 full of garbage door on the right side was wide open. The [NAME] stated the dumpster door should remain closed at all times to keep the bugs from getting inside. Interview on 05-29-2024 at 08:34 a.m. Dietary Manager (DM) stated the dumpster door should remain closed for infection control issues and to keep the bugs away. Interview on 05-29-2024 at 03:33 p.m. the Administrator stated all the staff do their best to ensure the dumpster remains closed and kept closed. He stated they had systems in place to avoid the door being found opened to include multiple monthly in-services with all departments on infection control and the DM checks the dumpster at the beginning of his shift. He stated there are multiple sources have accesses to the dumpster outside of the facility staff but ultimately it was the facility's responsibility to ensure the dumpster door remained closed. Record review of policy titled Garbage and Refuse Disposal with a revised date of October 2021 revealed: Food-related garbage and refuse are disposed of in accordance with current state laws. Policy Interpretation and Implementation 7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 4 of 5 staff (CNA K, Wound care nurse, CMA N, and Laundry aide A) and one(linen closet W) out of two clean linen closet observed for infection control. 1. The facility failed to ensure CNA K followed proper infection control and hand washing procedure during incontinent care for Resident #24. wound care. 2. CMA N did not sanitize the plastic medication container after using to administer medication for Resident #20 3. CMA N did not wash her hands prior to administering eye drops for Resident #24. 4. The facility failed to ensure to ensure clean item was not stored on the floor in the west clean linen closet. 5. The facility failed to ensure laundry aide A followed proper hand washing technique and infection control procedure when she demonstrated hand washing after loading dirty linen in the washing machine. These failures could place the residents at risk for infection. Findings included: 1.Record review of Resident #24 face sheet dated 05/30/24 revealed a [AGE] year-old male was admitted to the facility on [DATE]. Resident [NAME] had diagnoses included: hypertensive heart disease (a group of heart problems that occur when high blood pressure is present over a long period of time), peripheral vascular disease (is a circulatory condition that occur when blood vessels outside of the heart and brain narrow, block blood flow to other parts of the body), diabetes mellitus (a disease of inadequate control of blood levels of glucose), and hemiplegia(paralysis that affects only one side of the body). Record review of Resident 24's quarterly MDS assessment dated [DATE] revealed: Resident [NAME] had BIMS of 14 out of 15 indicated intact cognition. Further review revealed Resident [NAME] was extensive to depended on staff for ADL care. Record review of Resident #24's Physician orders reflected the following order: -Dated 12/29/2022 Dorzolamide-timolol instill 1 (one) drop in both eyes two times a day for glaucoma. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #24's care plan initiated 08/11/21 revealed Resident [NAME] has ADL self-care performance deficit related to disease process CVA with right sided Hemiplegia. Intervention: Toilet use: The resident is not toileted, requiring incontinent episode care with each incontinent episode. Further review of the care plan revealed dated 00/13/23 that resident was being care planned for impaired vision related to glaucoma with intervention to administer eye drop dorzolamide-timolol 1 drop in both eyes two times a day for glaucoma. During an observation on 05/29/24 at 10:30 a.m., CNA K provided incontinent care for Resident #24. CNA K changed her gloves but did not wash or sanitize her hands before she donned other gloves after cleaning the Resident #24 peri area. CNA K used the same gloves she cleaned Resident#24's buttocks and rectum, applied a clean incontinent brief, and repositioned and covered Resident #24. CNA K washed her hands after she provided care for Resident #24, and she used the wet paper towel which was wet and turned off the water faucet. During an interview on 05/29/24 at 10:56 a.m., CNA K said there was no reason for not sanitizing her hand when she changed her gloves after she cleaned Resident #24 peri area. She said she did not have sanitizer with the incontinent care supply on the table. CNA K said hands are sanitized to prevent the spread of germs. CNA K said she forgot to change the gloves after she cleaned Resident #24 buttocks and rectum before she took the clean brief with the dirty gloves and applied the brief on Resident #24. CNA K said she could have transferred the germs from the dirty gloves to the clean brief. CNA K said she was in service on infection control, including PPE and hand washing. CNA K said she used the same paper towel, dried her hands, and turned off the water tap. CNA K said she could have reinfected her hands with the germs. CNA K said if the germs get to the residents, they could get an infection. CNA K said the nurse monitors the aide during care, and she had skills check-off and in-service in providing incontinent care for the residents. During an interview on 05/30/24 at 1:48 p.m., the DON said CNA K should have sanitized her hands when she changed her gloves after she cleaned Resident #24's peri area. The DON said CNA K should have changed her gloves before she took a clean incontinent brief and applied it to Resident #24 before dressing him. The DON said CNA K could have put Resident #24 at risk of infection when she dressed him with dirty gloves. During an interview on 05/31/24 at 9:34 p.m., the DON said he expected CNA K to follow the infection control procedures they were in serviced on monthly, which included hand washing. The DON said he expected CNA K to use a dry paper towel to turn off the water faucet to prevent cross-contamination. 2.Observation on 05/30/2024 at 9:00AM CMA N walked in Resident #24's room with a pair of gloves in hand to administer the medication eye drop dorzolamide-timolol. Resident #24 asked for a soda out of his personal fridge. CMA N got the soda out of the fridge and gave to Resident #24. CMA N proceeded to place the pair of gloves on without washing her hands and proceeded to administer the eye drop 1 drop in each eye. After administering the eye drops, CMA removed her gloves and washed her hands. Interview on 05/30/2024 at 9:08AM CMA N said the reason she had not washed her hands prior to administering eyedrops to both of Resident #24 eyes was because she had already washed her hands earlier in another resident room after administering medications and therefore did not feel she needed to wash her hands again. CMA N said she became nervous and forgot to wash her hands again prior to administering eye drops to Resident #24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2024
NAME OF PROVIDER OR SUPPLIER Houston Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8550 Jason Street Houston, TX 77074	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/30/24 at 9:35AM the DON said he was the NF Infection Control Nurse and the Infection Control Preventionist. The DON said the staff received in-services monthly on infection control. The DON said when administering eyedrops, one should wash hands prior to administering eyedrops and afterwards for infection control. Record review of the facility policy on Instillation of Eye Drops dated 2001 revealed in part: .The purpose of this procedure is to provide guidelines for installation of eye drops to treat medical conditions, eye infections and dry eyes .wash and dry your hands thoroughly .put on gloves . 4. Record review of Resident #20's face sheet dated 05/01/2024 revealed an 83year old male admitted to the NF on 04/12/2024. Resident diagnoses included the following: type two diabetes mellitus (when the body has difficulty controlling blood sugar and using for energy), dementia (memory loss and judgement), peripheral vascular disease (narrowing of blood vessels causing a decrease in blood flow to the limbs), dysphagia (difficulty swallowing), and muscle weakness. Record review of Resident #20's MDS dated [DATE] revealed that resident had a BIMS score of 10 indicating that resident cognition was moderately impaired. Record review of Resident #20's Physician Orders for the month of May 2024 reflected the following orders: -Aspirin 81mg give 1 (one)tablet by mouth once a day -Plavix 75mg give 1 tablet by mouth once a day -Miralax 17 gm by mouth once a day (mix in 8 ounces of water) -Senna 8.6mg give 1 tablet by mouth once a day -Acetaminophen 500mg give 1 tablet by mouth three time a day -Lidocaine Patch 4% apply to right leg, left leg, and back topically one time a day for pain, remove after 12 hours and remove per schedule Observation on 05/30/24 at 8:12AM CMA N placed Resident #20's medications inside of a clear plastic container and carried into Resident #20's room to administer. CMA N placed the clear plastic container on top of Resident #20's bedside table. When CMA N finished administering the medications, she washed her hands and took the medication container out of the room and placed on top of another medication cart and proceeded to go down the hallway. Interview on 05/30/24 at 8:48AM CMA N said she sanitized the plastic medication bend once a day on her shift but guessed she could have sanitized the plastic container after removing from Resident #20's room. CMA N said the last in-service she received on infection Control was about a year ago regarding CNA as it related to resident care. CMA N said she done this in-service/training online. Interview on 05/30/24 at 9:35AM the DON said when medication containers are taken in a resident room, the container must be sanitized after each use because of infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy on Instillation of Eye Drops dated 2001 revealed in part: .The purpose of this procedure is to provide guidelines for installation of eye drops to treat medical conditions, eye infections and dry eyes .wash and dry your hands thoroughly .put on gloves . 5. During an observation and interview with the maintenance director on 05/30/24 at 11:27 a.m., it was revealed that a deflated air mattress was in a clear trash bag and on the floor under the rack in the west clean linen room. The Maintenance director said the bag with the air mattress should not be placed on the floor because of infection control. The maintenance director said he did not know who placed it on the floor, and it should not be stored in the clean linen room. 6. During an observation and interview on 05/30/24 at 11:37 a.m., Laundry aide A demonstrated how she would wash her hands after she loaded the washer with dirty linen before she went over to the clean linen. Laundry aide A turned the water faucet off with her wet hand and then dried her. The maintenance director interpreted for laundry aide A, and she said she forgot to dry her hands first before she turned off the water faucet with dry paper. Laundry aide A said she should have turned off the water faucet with a dry paper towel to prevent infection control. Record review of the facility Policy on Handwashing/Hand Hygiene revised October 2023 revealed in part . This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Indications of hand hygiene .immediately before touching a resident and after touching a resident . Indications for Hand Hygiene . #1Hand hygiene is indicated #1f . before moving from work on a soiled body site to a clean body site on the same resident .#1g .immediately after glove removal . Washing Hand #4 . Use towel to turn off the faucet . 36918