STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676450	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terra Bella Health and Wellness Suites	12262 Cityscape Ave Houston, TX 77047

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Resident #3) reviewed for care plans in that: -The facility failed to ensure Resident #3 received Bactroban and Calcium Alginate as ordered by the Wound Care Doctor on 01/11/2024. This failure could place residents at-risk of not receiving needed medication and delay necessary medical treatment. Finding included: Record review of the admission sheet for Resident #3 revealed he was [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnoses included: quadriplegia (a form of paralysis that affects all four limbs, plus the torso), pressure ulcer of sacral region, stage 4 (deep wounds that may impact muscle, tendons, ligaments, and bone) and type 2 diabetes mellitus with hyperglycemia (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of Resident#3 Comprehensive MDS assessment, dated 01/02/2024, revealed a BIMS score of 13 out of 15 indicating intact cognitively. Resident required total dependence from two person physical assist from staff for bed mobility, transfer, eating and toilet use. Further review of Section M0210. Unhealed Pressure Ulcers/Injuries-Does this resident had one or more unhealed pressure ulcers/injuries? Coded: Yes. D. 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 included undermining and tunneling. Number of Stage 4 pressure ulcers. Coded-3 Record review of Resident#3's care plan, initiated 07/18/2020 and revised on 11/04/2023, revealed the following: Focus: (Resident#3) has a Stage 4 pressure injury to his Sacrum. Goal: wound to heal without complications. Target Date: 03/29/2024. Approach: Follow MD orders as provided by MD Provide low air loss mattress Report any abnormal conditions to MD immediately Medicate for pain as needed. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident#3's physician order dated 08/17/2023 revealed an order to cleanse left buttock wound with ns, pat dry, apply Santyl, silver alginate and cover with dry dressing once a day 7:00am-7:00pm. Record review of Resident#3's physician order dated 09/06/2023 revealed an order to cleanse right buttock wound with ns, pat dry, apply alginate w/silver, apply Santyl and cover with dry dressing once a day 7:00am-7:00pm. Record review of Resident#3's physician order, dated 11/10/2023 revealed an order to cleanse sacral wound with ns/wound cleaner, pat dry, apply alginate w/silver, apply Santyl and cover with dry dressing once a day 7:00am-7:00pm. Record review of Resident#3's physician order for the month of January 2024 revealed there was no order entered in resident's EMR for Bactroban. Record review of Resident#3's Wound Care evaluation dated 01/11/2024 revealed read in part: . Wound #2-Right Buttock-Stage 4. Length: 5.9, Width: 2.7, Depth: 0.4cm. Physician Order- Clean with NS, apply Santyl, Bactroban, Alginate and cover with dry dressing daily. S/S of Infection-S/S Present: Yes. Confirmation Description & Treatment Plan: Signs & Symptoms Present , Systemic Antibiotics Prescribed, Topical Antibiotics Prescribed . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/14/24 at 12:50p.m., revealed ADON A provided wound care for Resident #3. ADON A was assisted by CNA A. ADON A gathered the supplies at the treatment cart in the hallway before bringing them into Resident's room. Prior to initiation of the treatment, Resident was assisted on to his right side. The ADON A unhooked the foley catheter from the right side of the bedframe and placed the catheter on the bed next to resident's legs. ADON A removed the resident's soiled Left buttock wound dressing and placed in the trash can sitting by the foot of resident's bed. The dressing contained a moderate amount of serosanguinous drainage. No foul odor was noted. There was no date visible on the dressing. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON A then cleansed the pressure wound with the Normal saline solution x2. ADON A with soiled gloves applied Santyl and Silver Alginate to the wound bed, covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. The ADON A said, I am making dry dressing. ADON A removed her gloves. Washed her hands. Donned clean gloves and removed sacral area dressing. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON A then cleansed the pressure wound with the Normal saline solution x2. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON A then cleansed the pressure wound with the Normal saline solution x2. With the soiled gloves grabbed scissor and cut a small piece of Silver Alginate and placed it onto the wound bed. Covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. ADON A removed soiled gloves and washed her hands. The resident was assisted on to his left side by the CNA while the ADON A donned clean gloves ADON removed the resident's soiled Right buttock wound dressing and placed in the trash can sitting by the foot of resident's bed. The dressing contained a moderate amount of serosanguinous drainage. Foul odor was noted. There was no date visible on the dressing. Continued observation revealed an open area of approximately 5 centimeters in diameter. The ADON A then cleansed the pressure wound with the Normal saline solution x1. ADON A removed her soiled gloves without washing or sanitizing her hands and said, I need to go get gauze and went to her cart. Returned in few second sanitized her hand, donned clean gloves, and cleansed the pressure wound with Normal saline solution x1. Applied Santyl to the wound bed. Removed her soiled, without washing or sanitizing her hands and said, I need to go get Silver Alginate and went to her cart. Returned in few second sanitized her hand, donned clean gloves then applied Silver Alginate to the wound bed. Covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. (ADON A failed to apply Bactroban and calcium alginate as ordered by the Wound Care Doctor on 01/11/2024). Record review and interview on 01/14/24 beginning at 2:45p.m., Surveyor reviewed Resident #3's physician's order/Wound Care evaluation dated 01/11/24 with the ADON A. ADON A said she did not see the order for Bactroban and Calcium Alginate for Right buttock wound in Resident#3's Electronic medical record. The ADON A said she did not have Bactroban in the wound care nurse's cart. In an interview on 01/14/24 at 4:28p.m., with ADON A and ADON B. ADON A said the Wound Care Doctor rounded with the Wound Care Nurse every Thursday and sent over the wound evaluation to the facility on Friday. She said the Wound Care Nurse would then go over the wound evaluation for new order, recommendation, etc. she said the DON was assisting WCN with entering new orders from the wound evaluation in the electronic medical record. She said she did not get a chance to look over 01/11/24 recent wound evaluations. She said the Administrator sent the wound evaluation to the Surveyor yesterday (01/13/24) and she forwarded the same email to the Surveyor today (01/14/24). She said the new orders were not entered from the last wound care doctor's visit on 01/11/24 in the EMR. Therefore, she was not aware Resident #3 had an order for Bactroban. She said Bactroban was used to treat infections. She said it was important to follow physician's order for proper wound care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 01/14/24 at 5:04p.m., with the Wound Care Doctor, he said in the past he had concerns with Resident #3's wounds with infections. Resident was placed on systemic ABT. He said he ordered Bactroban prophylactic on last Thursday's visit (1/11/24) because the resident was incontinent of bowel. No policy on care plan provided on exit. Record review of facility's Physician Orders policy dated (May 5, 2023) revealed read in part: .Policy: The qualified licensed nurse will obtain and transcribe orders according to Facility Practice Guidelines. ADMISION: 1.The qualified licensed nurse completes an admission medication regimen review from the transfer record from an acute care hospital, home, or other entity. Refer to the Admission Medication Regimen Review in Pharmacy Services policy and procedure manual.2. A call is placed to the physician to confirm the orders and request any additional orders as needed. In the event the physician writing the transfer orders is not credentialed by the facility, the designated attending physician is contacted to confirm the transfer orders and request any additional orders .

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 47215 Based on observation, interview and record review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 14 residents (Resident#3 and #4) reviewed for pressure ulcers. -The facility failed to provide adequate treatment services to heal pressure ulcers for Resident #3's wound infection on the right buttock, stage 4 pressure ulcer injury that was noted on doctor's order for 12/29/2023. -The facility failed to ensure supplies were available for the ADON to provide adequate wound care treatment to Residents #3 and #4 on 1/14/2024. The ADON made her own dry dressing while providing treatment to Residents #3's and Resident #4's pressure ulcer by using gauze and tape. There were no sacral dressings or border gauze available for use. -The facility failed to follow the physician's orders while providing wound care treatment to Resident #3. The ADON did not give Bactroban which was an order given by the doctor to treat Resident #3's pressure ulcer. -The facility failed to ensure ADON A performed hand hygiene when moving from a dirty to clean site, while performing Resident #3's wound care on 01/14/2023. These failures could place residents with pressure ulcers at risk for developing new pressure ulcers or a decline in existing pressure ulcers. An Immediate Jeopardy (IJ) was identified on 01/15/2024 at 3:11 PM. While the IJ was removed on 01/18/2024 at 3:30 PM, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that was not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. These findings included: Resident#3 Resident #3's face sheet revealed he was a [AGE] year-old man, admitted to the facility on [DATE] and readmitted on [DATE]. His diagnosis included, quadriplegia, abnormal blood-gas level (may be due to lung, kidney, metabolic diseases, or medicines), urinary tract infection (an infection in any part of the urine system, the kidneys, bladder, or urethra), need assistance for personal care, pain in unspecified joint, type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), and neurogenic bowel (loss of normal bowel function, caused by a nerve problem). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed BIMS score of 13, indicating cognition is intact. Further review of Resident 3's MDS revealed he needed total dependence for bed mobility and transfer and needed two persons physical assistance. He was total dependence for eating and toilet use and needed one-person physical assistance. Record review of Resident #3's care plan dated 11/30/2023 revealed Resident #3's problem is pressure ulcer injury. It revealed, Resident #3 has a stage 4 pressure injury to his sacrum. The goal: wound to heal without complications. Approach: follow MD orders as provided by MD, provide low air loss mattress, report any abnormal conditions to MD immediately, medicate for pain as needed. It also revealed stage III pressure injury to Rt elbow, pressure ulcer will heal without complications. Goal: keep clean and dry as possible, minimize skin exposure to moisture, lab work as ordered by physician. Record Review of Resident #3's physician orders dated 1/11/2024 revealed, wound number: 7, wound location: right buttock, wound type: stage 4 pressure ulcer, acquired wound condition: chronic, wound status: not healed. Cleanse wound with normal saline, apply Santyl, apply Bactroban, apply alginate, cover wound with dry absorptive dressing, and change dressing daily. The benefits of risk debridement with alternatives were discussed with Resident #3 who agreed with procedure on 1/11/2024. Record Review of Resident #3's physician orders dated 12/28/2023 revealed Resident 3's wound is infected and was acquired on 6/23/2021. Wound #7 S/S (signs and symptoms) infection confirmation description and treatment plan. Signs and symptoms present, systemic antibiotics prescribed, topical antibiotics prescribed. Observation and interview on 1/13/2024 beginning at 4:16p.m. with Resident #3, revealed him lying in bed with a bed table over him and he was watching television. He had an air mattress and boots on both feet. He also had a catheter. The resident is lying on a draw sheet. The wound Care Nurse and CNA A revealed that Resident #3 had an ABD pad and tape covering his wound in place of the dry dressing that was documented in the physician orders. The ABD pad was covering a sacral wound on the left and right buttocks. Resident #3 said the facility ran out of supplies. He said they ran out of bandages and the strap to hold his catheter cord in place. He said staff comes and change his wounds, but they do not use the correct supplies to cover his wounds. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Nurse Surveyor Observation on 1/14/24 at 12:50p.m. revealed the ADON provided wound care for Resident #3. The ADON was assisted by CNA A. The ADON gathered the supplies at the treatment cart in the hallway before bringing them into Resident #3's room. Prior to initiation of the treatment, Resident #3 was assisted onto his right side. The ADON unhooked the foley catheter from the right side of the bedframe and placed the catheter on the bed next to Resident 3's legs. The ADON removed the Resident #3's soiled, left buttock, wound dressing, and placed it in the trash can, sitting by the foot of his bed. The dressing contained a moderate amount of serosanguinous drainage. No foul odor was noted. There was no date visible on the dressing. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON then cleansed the pressure wound with the normal saline solution x2. The ADON, with soiled gloves, applied Santyl and Silver Alginate to the wound bed, covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. The ADON said, I am making dry dressing. The ADON removed her gloves, washed her hands, donned clean gloves, and removed sacral area dressing. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON then cleansed the pressure wound with the Normal saline solution x2. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON then cleansed the pressure wound with the normal saline solution x2. With the soiled gloves grabbed scissor and cut a small piece of Silver Alginate and placed it onto the wound bed. Covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. ADON removed soiled gloves and washed her hands. Resident #3 was assisted onto his left side by CNA A while the ADON donned clean gloves. The ADON removed the Resident #3's soiled Right buttock wound dressing and placed in the trash can sitting by the foot of his bed. The dressing contained a moderate amount of serosanguinous drainage. Foul odor was noted. There was no date visible on the dressing. Continued observation revealed an open area of approximately 5 centimeters in diameter. The ADON then cleansed the pressure wound with the Normal saline solution x1. ADON removed her soiled gloves without washing or sanitizing her hands and said, I need to go get gauze and went to her cart. She returned a few seconds later and sanitized her hands, donned clean gloves, and cleansed the pressure wound with Normal saline solution x1. Applied Santyl to the wound bed. Removed her soiled gloves, without washing or sanitizing her hands and said, I need to go get Silver Alginate and went to her cart. Returned in few second sanitized her hand, donned clean gloves then applied Silver Alginate to the wound bed. Covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. (The ADON failed to apply Bactroban and Alginate as per physician orders -wound evaluation dated 1/11/24). Resident #3's foley was on the bed while the ADON provided wound care. Interview on 1/14/2024 at 2:45p.m. with the ADON. The Interviewer reviewed Resident #3's physician's order with the ADON. The ADON said she did not see the order for Bactroban and Calcium Alginate for Right buttock wound in the Matrix. The ADON said she did not have Bactroban in the wound care nurse's cart. The ADON said she was unable to find the border dressing in the wound care cart. She said, I don't know where the wound care nurse kept the dressing. Therefore, I made my own dry dressing using the gauze and tape. The ADON said the foley should have been placed below and not on the bed with the Resident #3 during wound care. She said the risk would be contamination and back flow of urine. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Follow-up interview on 1/14/2024 at 4:28p.m. with ADON A and ADON B., ADON A said the Wound Care Doctor rounded with the Wound Care Nurse every Thursday and sent over the wound evaluation to the facility on Friday. The ADON said the Wound Care Nurse would then go over the wound evaluation for new order, recommendation, etc. She said the DON was assisting the Wound Care Nurse with entering new orders from the wound evaluation in the Matrix . She said she did not get a chance to look over 1/11/24 recent wound evaluations. She said the Administrator sent the wound evaluation to the Interviewer on yesterday (1/13/24) and she forwarded the same email to the Interviewer today (1/14/24). She said the new orders were not entered from the last Wound Care Doctor's visit on 1/11/24. Therefore, she was not aware Resident #3 had an order for Bactroban. She said Bactroban was used to treat infections. She said it was important to follow physician's order for proper wound care. The Interviewer shared Resident #3's Wound Care from earlier that day (1/14/2024) during the wound care treatment. The ADON said she should have washed/sanitized her hands after cleaning the wound, dirty to clean and prior to placing the clean dressing on the wound. The ADON she was waiting for the Wound Care Nurse to get to the facility. She said when she found out that Wound Care Nurse quit on them today 1/14/2024, she had to take care and to the wound care for the Surveyor. She said there was no border dressing in the wound care nurse cart. So, I made my own . It's clean environment. The gauze did not have to be sterile. Interview on 1/14/2024 at 5:04p.m. with the Wound Care Doctor, he said in the past he had concerns with Resident #3's wounds with infections. Resident #3 was placed on systemic antibiotics. He said he ordered Bactroban prophylactic last Thursday's visit (1/11/24) because the Resident #3 was incontinent of bowel. The Wound Care Doctor said, it's unorthodox using gauze. He said gauze did not have absorption capability like a typical boarder dressing. He said giving the fact the facility is in short supply. He said it would affect the wound if no proper infection control was used during wound care. Observation and interview on 1/15/2024 beginning at 4:28p.m. with Resident #3 revealed him lying in bed watching television. He said staff came in this morning and gave him a new dressing. He said he was feeling fine. Observation and interview on 1/18/2024 beginning at 1:58p.m revealed Resident #3 lying in bed with a blanket covering him up to his chest. He had the television on and a bed tray over his bed. He said staff has been working on his wound and has been covering it properly. He said they changed his dressing daily and he was in no pain. Resident#4 Resident #4's face sheet revealed he was a [AGE] year-old woman, admitted to the facility on [DATE]. Her diagnosis is dementia, muscle weakness, pressure ulcer of right hip stage 3, dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus ., hypertension, and contracture right hand (an abnormal thickening of tissues in the palm of the hand. Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score of 99, indicating resident was unable to complete interview. Further review of Resident #4's MDS revealed she was needed extensive assistance and one-person physical assistance for bed mobility, total dependence and two persons physical assistance for transfer and total dependence and one-person physical assistance for eating and toilet use. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's care plan dated 8/3/2023 revealed Resident #4's problem was pressure ulcer/injury. Resident #4 was at risk for skin breakdown. Long term target date: 12/8/2023, skin will remain clean, dry, and intact without evidence of breakdown through the nest review date. Approach: monitor for incontinence per routine rounds and prn change promptly, monitor for skin breakdown report to M.D. and R.P. Record Review of Resident #4's physician orders dated 1/11/2024 revealed, wound number: 2, wound location: right hip, wound type: stage 3 pressure injury. Clean wound with normal saline, fill wound with iodoform, cover wound with dry absorptive dressing, change dressing daily, reposition per facility protocol, and off load wound. Observation on 1/13/2024 1:45p.m. with Resident #4, revealed her lying asleep in bed. The bed was in a low position. There is a floor mat on the right side of the bed. There is a blue blanket covering resident up to her chest. There is a wheelchair in her room. The television was on and there are pillows on the resident's right side. Observation on 1/13/2024 at 4:23p.m. with Resident #4 revealed her with a border gauze on her buttocks. It is a small patch. The Wound care Nurse said she used the last border gauze on the Resident #4 and tonight she will have to use something else to substitute for the dressing. Observation on 1/15/2024 at 4:03p.m. with Resident #4 revealed her lying asleep in bed. She has a blanket covering her up to her chest. The call light is on top of the blanket. The television was on and the bed was in a low position. Floor mat was on the left side of the bed. Interview on 1/13/2024 at 1:00p.m. with Family Member A said, she spoke to the Wound Care Nurse and informed her that Resident #4, did not have a dry dressing on her wound. She said she asked the ADON and the Social Worker to look at the wound. She said they looked at the wound and they were baffled when they notice there was not a dry dressing covering Resident #4's wound. She said they told her they would train their CNAs better. She said staff lied about having medical supplies. She said for two weeks or more there were no medical supplies to treat the resident's wounds. She said the ADON apologized to her on 1/11/2024 for not having supplies. She said it was also verified by the medical records department that they were out of supplies. She said she had copies of the grievances she made concerning Resident #4's wounds. She said she comes to visit Resident #4 every day. She said Resident #4's other family comes to visit her at night. Family Member A said she sanitized the walls and doors in Resident #4's room. She said Resident #4 cannot do anything for herself. She said would like for Resident #4 to be treated with dignity and loyalty. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 1/13/2024 at 2:40p.m. the Wound Care Nurse said she had been working at the facility for 6 months. She said she changed the resident's dressings daily. She said she did admissions skin checks, and readmission from the hospital. She said she did treatments for skin and wounds. She said she used sacral dressings, 4X4 border gauze, and waterproof dressings to treat the wounds. She said normally she would have what she needed to treat the resident's wounds, but lately she did not have what she needed. She said she had been using ABD pads and Kerlix in place of the dressings. She said she had been using those items because she did not have the normal dry dressings that she normally used. She said the facility is low on supplies. She said the Central Supply person who oversees the ordering of the supplies, could not put in the orders because she had to receive permission from the Administrator. She said the Central Supply person was told by the Administrator not to order the supplies due to budget. She said the DON told her to put in an order and she put in an order last week, but when shipment came it was not on the order list. She said she was not sure if they will have supplies next week. She said the facility had been without supplies for a month now. Observation on 1/13/2024 at 3:36p.m. revealed, on the wound care cart, there was only Alginate strips (absorb wound fluid resulting in gels that maintain a physiology moist environment) on the cart. There were no other supplies available on the wound care cart. There was an empty box of border gauze. Interview on 1/13/2024 at 3:40p.m. with the Wound Care Nurse, said she ran out of border gauze weeks ago. She said had to use abdominal pads and tape in place of the regular dressings. Follow-up interview on 1/13/2024 at 4:50p.m. with the Wound Care Nurse said she informed the Doctor that the facility ran out of supplies, and they have been substituting the dressings with ABD (abdominal gauze) pads. She said she told him they have not ordered wound care supplies. She said the Doctor told her he has never heard of that before. She said he told her that the facility needs to get supplies. Interview on 1/14/2024 at 11:50a.m. with the Wound Care Doctor , he said the Wound Care Nurse left a message regarding the shortage of supplies at the facility. He said the dry dressings and the border gauze are primary dressings and secondary dressing would be the abdominal pads. He said primary dressings are more important. He said Resident #4's wound was not doing well. He said Resident #4's wound was a medical copiability. He said wounds are stable for most residents. He said ABD pads were okay to use as a secondary dressing. He said he preferred the facility to use border gauze which is the primary dressing and order more supplies. Observation on 01/14/24 at 3:13p.m. revealed the ADON provided wound care for Resident #4. The ADON was assisted by CNA A. The ADON gathered the supplies at the treatment cart in the hallway before bringing them into Resident #4's room. Prior to initiation of the treatment, Resident #4 was assisted onto her left side. The ADON removed the Resident #4's soiled right hip area wound dressing and placed it in the trash can, sitting by the foot of her bed. The dressing contained a moderate amount of serosanguinous drainage. No foul odor was noted. The dressing was dated 1/13/24. Continued observation revealed an open area of approximately 0.3 centimeters in diameter. The ADON then cleansed the pressure wound with the normal saline solution x2, filled wound with iodoform and covered with 6x6-3/4 gauze and tape. The ADON said, the tape is not staying I will have to re-do the wound care. (continued on next page)

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	676450	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 1/14/24 at 3:40p.m. revealed CNA A provided Resident #4 with incontinence care. CNA A removed Resident #4's brief and tucked it under the resident's buttocks. CNA A did not spread Resident #4's labia to thoroughly clean the area and the resident's urinary meatus. CNA A assisted Resident #4 to turn onto her right side to clean her buttocks. CNA A, without removing her soiled gloves, tucked clean brief under the Resident 4's buttocks. CNA A opened Resident #4's side drawer and looked for wipes. With soiled gloves, CNA A applied (Vaseline-per family's request) on the Resident #4's buttocks. Then, removed her right-hand soiled glove (left-hand soiled glove on) and fasten the brief. CNA A completed perineal care and with the same soiled gloves on, touched the Resident #4's clean shirt, brief, sheet, and blanket. Observation on 1/14/2024 at 3:46p.m., ADON removed the gauze and tape recently placed on Resident #4's Right hip wound and placed a boarder dressing dated 1/14/24. The ADON said, We were able to find 3 boxes of the boarder dressings in the Hall 100's nurses' cart. Interview on 1/14/24 at 3:55p.m. with CNA A, she said she had been working at the facility for 3 years as a full-time employee. CNA A said she did not spread Resident #4's labia and clean her meatus during incontinent care. She said, I should have cleaned her properly. I got nervous. She said the failure placed Resident #4 at risk for infections. She said she could not recall doing CNA competency checks for incontinent care at the time of hire. She said she received training from school on how to perform incontinent care. She said she did not recall receiving training on proper incontinent at this facility at the time of hire. CNA A said she had not performed hand hygiene during the delivery of incontinent care to Resident #4, I was nervous. CNA A said her actions in not performing hand hygiene while changing gloves could result in cross contamination. She said she had completed in-service on infection control 2 to 3 months ago and could not recall the exact date. Interview on 1/15/2024 at 4:33p.m. with the Administrator, she said wound care supplies came in earlier in the day on 1/15/2024 from the company they order supplies from. Observation on 1/15/2024 at 4:39p.m. there were no supplies in the wound care office and there were no supplies on the wound care cart. Observation on 1/15/2024 at 4:45p.m. in central supply room, revealed border dressings: 16 boxes, sacral dressings - 0, Opti foam gentle-silicone faced foam boarder dressings: 4 boxes, alginate: 2 large boxes, 3 small boxes, and 8 strips. Kerlix: 13 super sponges and 13-25 comes in pack. Interview on 1/15/2024 at 4:51p.m., the Central Supply person said, she ordered supplies every week. She said she ordered whatever the wound care nurse told her to order. She said no one came to her and informed her that border gauze and sacral dressings were needed. She said she would leave a sheet of paper for staff to fill out if they were low on supplies. She said she would also put it in the nurse's station. She said she never told anyone that she was unable to order supplies due to budget. She said she had been working at the facility since May. Interview on 1/15/2024 at 5:03pm with the Administrator, she said the Central Supply person gets with the Wound Care Nurse and the DON to go over the order list and discuss what supplies are needed. She said before it is ordered the DON will review it. She said no one has come to her in months to tell her that they were low on supplies. She said not even the DON. She said there was a concern about supplies that was expressed by a family member. She said she went to the ADON and asked if they had supplies and the ADON checked to see if they had supplies and she said the supplies were there. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 1/16/2024 at 5:05p.m., DON said she looked at orders that were given to her by the Central Supply person and the Wound Care Nurse would write down what supplies were needed. She said she would print the list and bring it to the morning meetings to confirm the orders. She said the Central Supply person would give the order list to the Administrator for submission. She said the last time an order was placed was on 1/12/2024. She said she did not notice that she was low on supplies. She said she went on vacation December 2023 and came back 1/3/2024. She said when she returned from vacation, the Central Supply person told her she was instructed not to order supplies by the Administrator. She said she told her to go ahead and order the supplies and if there was any blow back , like any repercussions, it was on her. She said had she known they were low on supplies, she would have ordered it before she left for vacation. Interview on 1/16/2024 at 5:21p.m. with the ADON, she said the Wound Care Nurse would sit with the Central Supply person and the Central Supply person would give the order to the Administrator and the Administrator would submit the order. She said the DON would ask the Central Supply person if she needed wound care supplies. She said the Central Supply person told the DON they had just enough supplies until a new order came in. She said when the DON returned from vacation they were out of supplies. Observation and interview on 1/16/2024 beginning at 5:30p.m. with the ADON. In the central supply room, revealed 3 boxes of sacral dressings, 5 dressings in each box. The ADON said they did not order many sacral dressings due to budget. She said there was a process of ordering sacral dressings. She said the order was placed on Friday and it may come in on Tuesday. Follow-up interview on 1/17/2024 at 1:52p.m. with the DON, she said she was trained on 1/16/2024 and she is now responsible for ordering wound care supplies and will make sure they have enough supplies for the facility. She said she will take the invoice and compare it to the order, to make sure everything was delivered, and nothing was on back order. She said she was going to make sure supplies are available and would make sure the proper care was provided per the physician's order. She said if the supplies are not available, she said it could be an adverse reaction to the resident if they don't have what the physician ordered. Interview on 1/17/2024 at 2:06pm, with the Environmental Services Supervisor over housekeeping and laundry. She said she had ordered supplies at the facility in the past. She said the last time she ordered for central supplies was either march or April of 2023. She said she had not ordered anything recently. She said the Central Supply person took over her position when she was promoted as a supervisor over laundry. She said when she first started working with laundry there were a few items she needed that was not available, but she said that was only for less than a week. She said when she was short, she went to another building and restocked the supplies. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of the facility's policy titled Pressure Ulcers, dated 1/18/2017, read in part, .Pressure ulcers will be evaluated and treated in accordance with professional standards of practice to heal and prevent pressure ulcers unless clinically unavoidable. Evaluate the pressure ulcer initially for location; stage (see specific policy), size (in em's), sinus tracts, undermining, tunneling, exudate (type, odors), necrotic tissue, and the presence and or absence of granulation tissue and epithelialization. Determine and record the date of onset for each pressure ulcer identified as Stage II or greater. The date of onset is included in the information for the wound on the weekly wound tracking sheet and carried over week to week until healed. If a wound deteriorates to a higher stage, the original onset date is retained. For example, a Stage II pressure ulcer with an onset date of August 1 of this year that deteriorates to a Stage III or Stage IV, will continue to be tracked with an onset date of August, the concern is with the original date of the insult to the skin. Re-evaluate pressure ulcers at least weekly. If the patient's/resident's condition or the condition of the wound deteriorates, or if there is no significant progress within a reasonable time frame (2 weeks), the treatment plan should be re-evaluated. If the treatment plan is not changed, documentation should be provided as to why current treatment plan is being maintained . This was determined to be an Immediate Jeopardy (IJ) on 01/15/24 at 3:011 PM. The Administrator was notified. The Administrator was provided the Immediate Jeopardy template on 01/15/24 at 3:12 PM. The following Plan of Removal was submitted and accepted on 01/16/24 at 2:00 PM. Plan of Removal January 16, 2024 Immediate action: Other residents affected: o F686-- The facility failed to ensure Resident #1, Resident #2, and Resident #3, received adequate treatment services to heal pressure ulcers. o The facility failed to ensure supplies were available to provide adequate wound care treatment. o The facility failed to follow the doctor's order while providing wound care treatment. o Resident #1, Resident #2 and Resident #3's wound care orders were confirmed with wound physician to validate accuracy and needed supplies on 1/16/24. Nursing Management will validate proper medicine and supplies are being used by visual inspection on 1/16/24. o An audit of notes from the wound physician's current resident list will be completed by The Director of Nursing/Designee on 1/15/24 to identify new physician orders. Any orders identified will be implemented at time of discovery. o A physician order audit will be completed by the Director of Nursing/Designee on current residents with pressure wounds to validate appropriate supplies are available. If supplies are not available, physician will be notified for additional orders until supplies can be obtained from supplier. Supplies will be ordered and delivered to facility by 1/16/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Assistant Director of Nursing/designee will complete assessments on current residents with pressure wounds to identify signs and symptoms of infection on 1/15/24. If signs and symptoms of infection are present, physician will be notified upon discovery and additional orders obtained if directed. No additional residents with signs and symptoms of infection identified. One resident is being treated for infection since 1/3/24. Facilities Plan to Ensure Compliance and Monitoring: o Director of Nursing educated the wound physician on 1/16/24 to ensure a verbal exit with the Director of Nursing/Designee occurs prior to the physician leaving the building ensuring new orders are identified, carried out timely and supplies are available. o Licensed nurses were re-educated by the Director of Nursing/Designee on the exit process for the wound physician on 1/15/24 that includes ensuring a verbal exit is completed with the Director of Nursing/Designee prior to the physician leaving the building to ensure new are orders are identified, carried out timely and supplies are available. o Central Supply Person was reeducated by the Administrator/Designee on need for wound care supplies to be ordered timely and as needed per physician orders on 1/15/24. o Central Supply person will be provided a list of the current wound care case load and supplies needed by the Director of Nursing/Designee by 1/16/23. o Central Supply person will attend morning meeting to identify additional supplies needed through new orders or any supply issues. o Central Supply will order supplies per facility process weekly to ensure wound supplies are available for wound care. Any issues with supplies or anticipated issues with supplies will be discussed with the Director of Nursing upon notification so additional arrangements can be made to obtain supplies or physician notified for recommendations. o Licensed nurses will receive reeducation on wound care by the Director of Nursing/Designee by 1/16/24 including: o Providing treatment and care per physician's order o Validating supplies are available. If supplies are not available, notifying the physician for additional orders and notifying the Director of Nursing of need for supplies. o Licensed Nurses not receiving this education 1/15/24 will receive prior to their next scheduled shift and this will be completed in New Hire and agency orientation. o Licensed Nurses will have wound care competencies completed by the Director of Nursing/Designee including following physician order for supplies to be used and documentation with description of any observed changes in wound or skin integrity. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o These competencies will be completed by 1/16/24. Licensed nurses who have not completed a competency by this date will receive prior to their next scheduled shift and this will be completed in New Hire and agency orientation. o Ad Hoc QAPI will be held on 1/15/24. o The Medical Director was notified of the Immediate Jeopardy on 1/15/24. Surveyor Monitored the plan of removal as follows: Observations were started on 01/15/2024 and continued through 01/18/24. Observation of Resident (#1, #2, #3, #4, #5, #6, #7, #8,) revealed residents receive [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40249 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 2 of 3 residents (Resident ##3 and #4) observed for urinary incontinence. -CNA A did not practice proper technique while providing incontinent care for Resident #4. -ADON A placed catheter bag on the bed while performing wound care on Resident #4. -Resident #3 did not have the strap to his catheter that keeps the catheter from dislodging during an observation with the Interviewer on 1/13/2024, who was initially checking on residents who had pressure ulcers. These failures placed residents with indwelling catheters at risk for increased infections and hospitalization . Findings include: Resident#4 Record review of the admission sheet for Resident #4 revealed she was [AGE] year-old female admitted on [DATE]. Her diagnoses included: dementia (a group of thinking and social symptoms that interferes with daily functioning), pressure ulcer of right hip, stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed) and hypokalemia (low levels of potassium in blood). Record review of Resident#4 Comprehensive MDS assessment, dated 12/01/2023, revealed a BIMS score of 99 out of 15 indicating severely impaired cognitively. Resident required total dependence from two-person physical assist from staff for transfer, eating and toilet use. Further review of Section M0210. Unhealed Pressure Ulcers/Injuries-Does this resident had one or more unhealed pressure ulcers/injuries? Coded: Yes. C. 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. Coded-1 Record review of Resident#4's care plan, initiated 03/09/2023 and revised on 08/17/2023, revealed the following: Focus: (Resident#4) was at risk for unavoidable skin breakdown d/t impaired cognition, contractures, impaired communication, impaired mobility and incontinence of bowel and bladder. Goal: Skin will remain clean, dry and intact without evidence of breakdown thru the next review date. Long Term Goal Target Date: 12/08/2023. Approach: Monitor for incontinence per routine rounds and prn, change promptly. Monitor for skin break down, report to M.D. and R.P. Give meds per order, monitor labs - report abnormal to M.D. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/14/24 at 3:40p.m., revealed CNA A provided Resident #4 with incontinence care. CNA A removed Resident's brief and tucked it under the resident's buttocks. CNA A did not spread Resident's labia to thoroughly clean the area and the resident's urinary meatus. CNA A assisted Resident to turn onto her right side to clean her buttocks. CNA A without removing her soiled gloves, tucked clean brief under the resident's buttocks. CNA A opened resident's side drawer and looked for wipes. With soiled gloves CNA A applied (Vaseline-per family's request) on the resident's buttocks. Then, removed her right-hand soiled glove (left-hand soiled glove on) and fasten the brief. CNA completed perineal care and with the same soiled glove on, touched the Resident's clean shirt, brief, sheet, and blanket. In an interview on 01/14/24 at 3:55p.m., with CNA A, she said she had been working at the facility for the last 3 years as a full-time employee. CNA A said she did not spread Resident's labia and clean the resident's meatus during incontinent care. She said, I should have cleaned her properly. I got nervous. She said the failure placed the resident at risk for infections. She said she could not recall doing CNA competency checks for incontinent care at the time of hire. She said she received training from CNA school on how to perform incontinent care. She said she did not recall receiving training on proper incontinent at this facility at the time of hire. CNA A said she had not performed hand hygiene during the delivery of incontinent care to Resident I forgot. CNA A said her actions in not performing hand hygiene while changing gloves could result in cross contamination. She said she had completed in-service on infection control either 2 or 3 months ago and could not recall the exact date. In an interview on 1/14/24 at 4:28p.m., with the ADON A and ADON B Surveyor shared incontinent care observation from earlier. ADON A said she expected CNAs to follow policy and procedures while providing care. ADON B said she was the infection preventionist. She said she expected staff to follow standard infection control techniques; to perform handwashing before the treatment, between gloves change and after moving from dirty to clean site as it placed risk for infections. She said staff were provided in-service on different topics to include infection control/hand washing on going bases. She said CNA A had missed the last training held on (12/18/23) as she was out with COVID. She said the potential risk to the resident, due to this failure, was cross contamination. Resident#3 Resident #3's face sheet revealed he was a [AGE] year-old man, admitted to the facility on [DATE] and readmitted on [DATE]. His diagnosis included, quadriplegia, abnormal blood-gas level (may be due to lung, kidney, metabolic diseases, or medicines), urinary tract infection (an infection in any part of the urine system, the kidneys, bladder, or urethra), need assistance for personal care, pain in unspecified joint, type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), and neurogenic bowel (loss of normal bowel function. It is caused by a nerve problem). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed BIMS score of 13, indicating cognition is intact. Further review of Resident 3's MDS revealed he needed total dependence for bed mobility and transfer and needed two persons physical assistance. He was total dependence for eating and toilet use and needed one-person physical assistance. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's care plan dated 10/26/2023 revealed Resident #3's problem start date: 11/4/2023, category: indwelling catheter, Resident #3 requires an indwelling urinary catheter R/T Neurogenic bladder d/t spinal cord injury. Goal: Resident #3 will have care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma. Approach start date: 11/4/2023, use catheter a strap. Assure enough slack was left in the catheter between the meatus and strap. Observation and interview on 1/13//2024 beginning at 4:16p.m. with Resident #3 revealed him lying in bed with a bed table over him. He was watching television. He had an air mattress and heel pressure relief boots on both feet. He also had a catheter. Resident #3 was lying on a draw sheet. He had on a t-shirt and briefs. He said the facility ran out of bandages and the strap to hold his catheter cord in place. Interview on 1/14/2024 at 1:35p.m. with Resident #3 said the strap to his catheter has been missing for a week. He said when the nurses come to change him, they pull the strap out of place. Interview with LVN B said the strap to the catheter keeps the catheter in place and it keeps it from pulling out of place. He said the catheter was in Resident #3's growing area. He said if the strap was not attached to the catheter, it could pull out of place and cause trauma and pain to the resident. Interview on 1/14/2024 at 1:43p.m. with the ADON, she said the strap to the catheter keeps the catheter from dislodging. She said if the strap was dislodged, then Resident #3 will have to go to the hospital. She said Resident #3 can develop an infection by trying to put the catheter back in. She said it could cause Resident #3 pain. She said it was the nurse's responsibility to replace the strap. In an interview on 1/14/24 at 2:45p.m., The ADON said the foley should have been placed below and not on the bed with the resident during wound care. She said the risk would be contamination and back flow of urine. Follow-up interview on 1/14/2024 at 3:36p.m. with LVN B, he said some days he works the 400 hall where Resident #3 resides. He said the times he worked with Resident #3; he did not notice that the strap to the catheter was missing. He said normally there would be a strap there to keep the catheter in place. He said no one brought it to his attention. He said he would change the Resident #3s catheter every month. He said he went and got a strap from the DON. He said he did not know where she got it from because there were no straps in the supply room. Record Review of the facility's policy titled Pressure Ulcers, dated 1/18/2017, read in part, . Indwelling or intermittent urinary catheterization will be used for those patients/residents whose medical condition requires intervention for urinary elimination, or for those patients/residents whose condition requires intervention for urinary elimination techniques to protect skin surfaces. Catheters are only used in those circumstances in which no alternative is available. Use is primarily restricted to: Overflow incontinence with symptomatic infections/ or r-enal dysfunctions present. Resident has acute urinary retention (diagnosis of Neurogenic Bladder) or bladder outlet obstruction (diagnosis of Obstructive Uropathy). Need for accurate measurement of urinary output . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's Perineal Care/Incontinent Care policy dated (7/1/2016) revealed read in part: . Procedures: 8. For female patient/resident: A. Wash Labia Majora. 1) Separate labia to expose urethra meatus and vaginal orifice. Apply cleanser as directed. Wash downward from pubic area toward rectum in one smooth stroke. Use separate section of cloth for each stroke. 2) Retract labia from thigh, washing carefully in skin folds from perineum to rectum. Repeat on opposite side using separate section of washcloth. 3) If perinea! cleanser used, then pat dry . 47215

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676450	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terra Bella Health and Wellness Suites	12262 Cityscape Ave Houston, TX 77047

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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** 40249 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident #3 and #4) and 2 of 4 staff (ADON A and CNA A) reviewed for infection control, in that: -The facility failed to ensure ADON A performed hand hygiene when moving from a dirty to clean site, while performing Resident #3's wound care on 01/14/2023. -CNA A failed to properly change gloves and wash or sanitize her hands when moving from a dirty area to a clean area when incontinent care was provided to Resident #4 on 01/14/2023. These failures could place residents at risk for cross contamination, infections, delay in treatment and hospitalization . Findings included: Record review of the admission sheet for Resident #3 revealed he was [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnoses included: quadriplegia (a form of paralysis that affects all four limbs, plus the torso), pressure ulcer of sacral region, stage 4 (deep wounds that may impact muscle, tendons, ligaments, and bone) and type 2 diabetes mellitus with hyperglycemia (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of Resident#3 Comprehensive MDS assessment, dated 01/02/2024, revealed a BIMS score of 13 out of 15 indicating intact cognitively. Resident required total dependence from two-person physical assist from staff for bed mobility, transfer, eating and toilet use. Further review of Section M0210. Unhealed Pressure Ulcers/Injuries-Does this resident had one or more unhealed pressure ulcers/injuries? Coded: Yes. D. 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 included undermining and tunneling. Number of Stage 4 pressure ulcers, Coded-3. Record review of Resident#3's care plan, initiated 07/18/2020 and revised on 11/04/2023, revealed the following: Focus: (Resident#3) has a Stage 4 pressure injury to his Sacrum. Goal: wound to heal without complications. Target Date: 03/29/2024. Approach: Follow MD orders as provided by MD Provide low air loss mattress report any abnormal conditions to MD immediately Medicate for pain as needed. Record review of Resident#3's physician order dated 08/17/2023 revealed an order to cleanse left buttock wound with ns, pat dry, apply Santyl, silver alginate and cover with dry dressing once a day 7:00am-7:00pm. (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#3's physician order dated 09/06/2023 revealed an order to cleanse right buttock wound with ns, pat dry, apply alginate w/silver, apply Santyl and cover with dry dressing once a day 7:00am-7:00pm. Record review of Resident#3's physician order, dated 11/10/2023 revealed an order to cleanse sacral wound with ns/wound cleaner, pat dry, apply alginate w/silver, apply Santyl and cover with dry dressing once a day 7:00am-7:00pm. Record review of Resident#3's Wound Care evaluation dated 01/11/2024 revealed read in part: Wound#1 Sacral -Stage 4 Length: 3.8, Width: 0.4, Depth: 0.4cm. Physician Order- clean with NS, apply Alginate /w Silver and cover with dry dressing daily. Wound #2-Right Buttock-Stage 4. Length: 5.9, Width: 2.7, Depth: 0. 4cm. Physician Order- Clean with NS, apply Santyl, Bactroban, Alginate and cover with dry dressing daily. Wound#3-Left Buttock-Stage 4 Length: 3.4, Width: 1.8, Depth: 0.3cm. Physician Order- Clean with NS, apply Alginate w/silver and cover with dry dressing daily . Observation on 01/14/24 at 12:50p.m., revealed ADON A provided wound care for Resident #3. ADON A was assisted by CNA A. ADON A gathered the supplies at the treatment cart in the hallway before bringing them into Resident's room. Prior to initiation of the treatment, Resident was assisted on to his right side. The ADON A unhooked the foley catheter from the right side of the bedframe and placed the catheter on the bed next to resident's legs. ADON A removed the resident's soiled Left buttock wound dressing and placed in the trash can sitting by the foot of resident's bed. The dressing contained a moderate amount of serosanguinous drainage. No foul odor was noted. There was no date visible on the dressing. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON A then cleansed the pressure wound with the Normal saline solution x2. ADON A with soiled gloves applied Santyl and Silver Alginate to the wound bed, covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. The ADON A said, I am making dry dressing. ADON A removed her gloves. Washed her hands. Donned clean gloves and removed sacral area dressing. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON A then cleansed the pressure wound with the Normal saline solution x2. Continued observation revealed an open area of approximately 3 centimeters in diameter. The ADON A then cleansed the pressure wound with the Normal saline solution x2. With the soiled gloves grabbed scissor and cut a small piece of Silver Alginate and placed it onto the wound bed. Covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. ADON A removed soiled gloves and washed her hands. The resident was assisted on to his left side by the CNA while the ADON A donned clean gloves ADON removed the resident's soiled Right buttock wound dressing and placed in the trash can sitting by the foot of resident's bed. The dressing contained a moderate amount of serosanguinous drainage. Foul odor was noted. There was no date visible on the dressing. Continued observation revealed an open area of approximately 5 centimeters in diameter. The ADON A then cleansed the pressure wound with the Normal saline solution x1. ADON A removed her soiled gloves without washing or sanitizing her hands and said, I need to go get gauze and went to her cart. Returned in few second sanitized her hand, donned clean gloves, and cleansed the pressure wound with Normal saline solution x1. Applied Santyl to the wound bed. Removed her soiled, without washing or sanitizing her hands and said, I need to go get Silver Alginate and went to her cart. Returned in few second sanitized her hand, donned clean gloves then applied Silver Alginate to the wound bed. Covered with Kerlix super sponges measured 6x6-3/4 and hypafix adhesive non-woven fabric band. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/14/24 at 4:28p.m., with ADON A and ADON B. Surveyor shared wound care observation from earlier. The ADON A said she should have washed/sanitized her hands after cleaning the wound, dirty to clean and prior to placing the clean dressing on the wound as this failure placed risk for infections. Record review of the admission sheet for Resident #4 revealed she was [AGE] year-old female admitted on [DATE]. Her diagnoses included: dementia (a group of thinking and social symptoms that interferes with daily functioning), pressure ulcer of right hip, stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed) and hypokalemia (low levels of potassium in blood). Record review of Resident#4 Comprehensive MDS assessment, dated 12/01/2023, revealed a BIMS score of 99 out of 15 indicating severely impaired cognitively. Resident required total dependence from two-person physical assist from staff for transfer, eating and toilet use. Further review of Section M0210. Unhealed Pressure Ulcers/Injuries-Does this resident had one or more unhealed pressure ulcers/injuries? Coded: Yes. C. 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. Coded-1 Record review of Resident#4's care plan, initiated 03/09/2023 and revised on 08/17/2023, revealed the following: Focus: (Resident#4) was at risk for unavoidable skin breakdown d/t impaired cognition, contractures, impaired communication, impaired mobility and incontinence of bowel and bladder. Goal: Skin will remain clean, dry and intact without evidence of breakdown thru the next review date. Long Term Goal Target Date: 12/08/2023. Approach: Monitor for incontinence per routine rounds and prn, change promptly. Monitor for skin break down, report to M.D. and R.P. Give meds per order, monitor labs - report abnormal to M.D. Observation on 1/14/24 at 3:40p.m., revealed CNA A provided Resident #4 with incontinence care. CNA A removed Resident's brief and tucked it under the resident's buttocks. CNA A did not spread Resident's labia to thoroughly clean the area and the resident's urinary meatus. CNA A assisted Resident to turn onto her right side to clean her buttocks. CNA A without removing her soiled gloves, tucked clean brief under the resident's buttocks. CNA A opened resident's side drawer and looked for wipes. With soiled gloves CNA A applied (Vaseline-per family's request) on the resident's buttocks. Then, removed her right-hand soiled glove (left-hand soiled glove on) and fasten the brief. CNA completed perineal care and with the same soiled glove on, touched the Resident's clean shirt, brief, sheet and blanket. In an interview on 01/14/24 at 3:55p.m., with CNA A, she said she had been working at the facility for the last 3 years as a full-time employee. CNA A said she did not spread Resident's labia and clean the resident's meatus during incontinent care. She said, I should have cleaned her properly. I got nervous. She said the failure placed the resident at risk for infections. She said she could not recall doing CNA competency checks for incontinent care at the time of hire. She said she received training from CNA school on how to perform incontinent care. She said she did not recall receiving training on proper incontinent at this facility at the time of hire. CNA A said she had not performed hand hygiene during the delivery of incontinent care to Resident I forgot. CNA A said her actions in not performing hand hygiene while changing gloves could result in cross contamination. She said she had completed in-service on infection control either 2 or 3 months ago and could not recall the exact date. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/14/24 at 4:28p.m., with ADON A and ADON B Surveyor shared incontinent/wound care observation from earlier. ADON B said she was the infection preventionist. She said she expected staff to follow standard infection control techniques; to perform handwashing before the treatment, between gloves change and after moving from dirty to clean site as it placed risk for infections. She said staff were provided in-service on different topics to include infection control/hand washing on going bases. She said CNA A had missed the last training held on (12/18/23) as she was out with COVID. She said the potential risk to the resident, due to this failure, was cross contamination. In a telephone interview on 01/14/24 at 5:04p.m., with the Wound Care Doctor, he said it would affect the wound if no proper infection control was used during wound care. Record review of facility's Infection Prevention and Control policies and procedures dated (Revision: 9/2011) revealed read in part: .Subject: Hand Hygiene/Handwashing. Policy: Proper hand hygiene/ hand washing technique will be accomplished at all times that handwashing is indicated. Procedures: After-A. After contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. B. After patient/resident contact. C. After contact with a contaminated object or source where there is a concentration of microorganisms, such as, mucous membranes, non-intact skin, body fluids or wounds. D. After toileting or assisting others with toileting, or after personal grooming. H. After removal of medical/surgical or utility gloves . Record review of facility's Infection Prevention and Control policies and procedures dated (May 15, 2023) read in part: .Subject: Infection Prevention And Control Program and Plan. PURPOSE: To establish a facility wide program that incorporates a system for preventing, identifying reporting, investigating and controlling infections and communicable diseases. The program covers all residents, staff, consultants, students in the facility's nurse aide training program or from affiliated academic institutions, volunteers, visitors, and other individuals providing services under a contractual agreement and is based on the individual facility assessment following accepted national standards. 8.DEPARTMENT RESPONSIBILITIES: A. All department managers are oriented to infection control and prevention policies and procedures that relate to their department. B. Department Managers take responsibility for implementing such standards, and to verify staff understand and take an active role in infection prevention and control .