STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676454	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Katy, LLC	1222 Park West Green Drive Katy, TX 77493

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect for one (Resident #1) of one resident reviewed for dignity. The facility failed to ensure Resident #1's foley bag had a privacy bag covering it on 09/06/2024 while he sat in his wheelchair in his room. This failure could place residents in the facility at risk of feeling uncomfortable and disrespected. Findings included: Record review of Resident #1's face sheet dated 09/06/2024 revealed reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Resident#1 had diagnoses which included: malignant neoplasm of esophagus (cancer that forms in the esophagus), Type 2 Diabetes Mellitus (body cannot produce enough insulin or cannot use insulin properly), Hypertension (condition where the pressure in your blood vessels is always high), Atherosclerotic Heart Disease (thickening or hardening of the arteries), and Dysphagia (difficulty swallowing). Record review of Resident #1's admission MDS assessment dated [DATE] revealed reflected a BIMS (a brief interview to determine a person's cognitive intactness) score was not done. Record review of Resident #1's progress notes dated 9/6/20024 read in part . his BIMS score was a 13, indicating cognitive intactness . Record review of Resident #1's care plan initiated on 09/04/24 revealed Resident #1 has a urinary catheter. Interventions: check placement of tubing each shift. Record review of Resident #1's order summary report for September 2024 read in part . Nurse to update the size of foley catheter 16 FR/ 10 cc balloon upon admission active date 09/04/2024 . During an observation of Resident #1's care on 09/06/24 at 3:09 p.m., it revealed Resident #1's foley bag was hung under the wheelchair and had no privacy bag covering it. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Katy, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1222 Park West Green Drive Katy, TX 77493	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #1's care on 09/06/24 at 3:35 p.m., revealed RN A was observed seeing that Resident #1's foley bag did not have a privacy bag covering it. During an interview on 09/06/ 24 at 3:50 p.m., RN A said Resident #1's Foley bag should have a privacy bag to prevent others from seeing what was in the Foley bag, and it was a dignity issue. RN A said she was going to change the Foley bag to the facility Foley bag because the facility Foley bag had a privacy bag attached to it, but she had not gotten to changing the bag because she had been busy with residents. RN A said the DON monitored the nurses when she rounded. During an interview on 09/06/24 at 3:55 p.m., CNA M said Resident #1's Foley bag was not in a privacy bag, and it was a dignity issue because you did not want other people to see the Foley bag. CMA M said the nurses were responsible for changing out Resident #1's Foley bag when Resident #1 was admitted to the facility because the facility Foley had a privacy bag with it. CNA M said she had in-service on Foley care. During an interview on 09/06/24 at 6:41 p.m., the DON said Resident #1's Foley bag should be in a privacy bag because it was a dignity and privacy issue, which would prevent other people from seeing the content in the bag. The DON said the nurses should monitor the aides when the nurse rounded, and the DON monitored the nurses during rounding and also conducted in-service for the staff. Record review of the facility policy on resident rights dated April 2022, revision 05/2023 read in part . purpose . Purpose: To ensure each resident is treated with dignity and respect. This includes providing activities and interactions from staff . self-esteem, self-worth . Care and services respect individuality, while both honoring and valuing input .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 1 resident (Resident #1) reviewed for incontinent care. 1. The facility failed to ensure Resident #1 foley tubing was not touching the floor on 09/06/2024 while Resident was seated in his wheelchair. This failure could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #1's face sheet dated 09/06/2024 reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Resident#1 had diagnoses which included: malignant neoplasm of esophagus (cancer that forms in the of the esophagus), Type 2 Diabetes Mellitus (body cannot produce enough insulin or cannot use insulin properly), Hypertension (condition where the pressure in your blood vessels is always high), Atherosclerotic Heart Disease (thickening or hardening of the arteries), and Dysphagia(swallowing). Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score was not completed. Record review of Resident #1's progress notes dated 9/6/20024 read in part . his BIMS score was a 13, indicating cognitive intactness . Record review of Resident #1''s care plan initiated on 09/04/24 revealed Resident #1 has a urinary catheter. Interventions: check placement of tubing each shift. Record review of Resident #1's order summary report for September 2024 read in part . Nurse to update the size of foley catheter 16 FR/ 10 cc balloon upon admission active date 09/04/2024 . During an observation of Resident #1's care on 09/06/24 at 3:09 p.m., revealed Resident #1's foley tubing was touching the floor. During an observation of Resident #1's care on 09/06/24 at 3:35 p.m., revealed RN A observed the foley tubing was lying on the floor. During an interview on 09/06/24 at 3:47 p.m., RN A said Resident #1's foley tubing was lying on the floor. RN A said the tubing should not be touching the floor because microorganisms could enter Resident #1's urinary system and cause a urinary tract infection. RN A said she had no training or skills check-off for caring for a foley. RN A said the nurse monitored the aides during rounding, and the DON monitored the nurses when she rounded. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/06/24 at 3:55 p.m., CNA M said she assisted the PTA R when he transferred Resident #1 from the bed to the wheelchair around 12:00 p.m., and PTA R hung the foley bag on the wheelchair. CNA M said Resident #1's foley tubing should not touch the floor because of infection control. CNA M said Resident #1 could get an infection, but she did not know what type of infection because she was not a doctor. CNA M said she had training and in-service on infection control, and the nurse monitored the aides when she made rounds. During an interview on 09/06/24 at 6:38 p.m., The DON said Resident #1 foley tubing was not supposed to touch the floor because of infection control and resident #1 could get infection and the tubing could get kinked if Resident #1 rolled over the tubing with his wheelchair. The DON said the nurses monitored the aides, and she monitored the nurses. During an interview on 09/08/24 at 2:02 p.m., PTA R said he assisted the OT and CNA M when Resident #1 was transferred to the wheelchair on 09/06/24, and it was around lunchtime. PTA R said the foley bag should be placed on the X bar (cross bar) located under the wheelchair. PTA R said CNA M placed the bag under the wheelchair. He said he was unsure if the foley tubing was touching the floor after Resident #1 was transferred to the wheelchair. PTA R said the foley tubing should not touch the floor because the tube could become contaminated with the germs on the floor, and Resident #1 could get an infection. Record review of the facility policy on cauterization of urinary bladder dated November 2018, revision 04/2023 read in part . procedure #14 . Hang collection bag appropriately to the side of the bed, keeping it below the bladder and off the floor .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings, for 1 (Resident #1) of 2 resident that was reviewed for feeding tubes, in that: -The facility failed to ensure RN A appropriately verified placement, RN A should have listened to the bowel sounds, then checked the residual and water flush the tube before feeding for Resident #1 during a enteral bolus tube feeding on 09/06/2024. The water for the flush should be room temperature, not cold. RN A used cold water to flush after the enteral bolus feeding. This failure could place residents at risk for adverse reactions, inadequate therapy, and a decreased quality of life. Finding included: Record review of Resident #1's face sheet dated 09/06/2024 reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Resident#1 had diagnoses which included: malignant neoplasm of esophagus (cancer that forms in the of the esophagus), Type 2 Diabetes Mellitus (body cannot produce enough insulin or cannot use insulin properly), Hypertension (condition where the pressure in your blood vessels is always high), Atherosclerotic Heart Disease (thickening or hardening of the arteries), and Dysphagia(swallowing). Record review of Resident #1's admission MDS assessment dated [DATE] revealed reflected a BIMS score was not completed. Record review of Resident #1's progress notes dated 9/6/20024 read in part . his BIMS score was a 13, indicating cognitive intactness . Record review of Resident #1's care plan initiated on 09/04/24 reflected resident requires enteral nutrition. Interventions: listen to lung sounds as ordered. Record review of Resident #1's order summary report for September 2024 read in part . Nutren 1.5 give 250 ml or 1 can 4 times a day per G- tube four times a day for Supplement dated 09/04/24 . Record review of Resident #1's MAR dated July 2024 read . Enteral Feed Order every shift for Routine Care Check enteral tube placement via aspiration &auscultation immediately after insertion, before each feeding / flush, before medication administration, before performing gastric residual check &at least every 8 hours . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #1's bolus enteral feeding on 09/06/24 at 3:09 p.m.,, RN A took a pair of gloves from her cart and donned the gloves, and she took 250ml of a box of feeding formula and two clear plastic cups; one had cold water, and the other was empty. RN A did not don a disposal gown. When RN A went inside Resident #1's room, she placed the box of feeding formula and the two cups on the bedside table, which had two incontinent wipes on top of it, and she did not disinfect or place a barrier on the bedside table. RN A reached into Resident #1 nightstand drawer, took out the syringe, removed it from the plastic, took out the plunger, and placed it on the plastic from which she took the syringe. RN A took the stethoscope, which was hanging around her neck, and assessed Resident #1's abdominal quadrants without disinfecting the bell of the stethoscope. RN A did not check for residual or flush the feeding tube, and she administered the bolus enteral feeding to the resident. When RN A administered the bolus enteral feeding, she covered the syringe with the plastic cup that had the formula because Resident #1 was trying to cough. RN A flushed with 30 ml of cold water after feeding. RN A wore the same gloves and opened the restroom door, turned on the water faucet, rinsed the syringe, turned off the water faucet, took the paper tower from the paper tower folder, and dried the syringe. RN A returned to Resident #1's bedside table, took the plunger, inserted it back into the syringe, and placed it back into Resident #1's nightstand, still wearing the same gloves. During an interview on 09/06/24 at 3:40 p.m., RN A said that Resident #1's bedside table should be disinfected and that a barrier be placed on the table. RN A said she was supposed to check for residual amounts of formula in the stomach before feeding Resident #1. RN A said residual was checked to ensure Resident #1 tolerated the last feeding. RN A said she went too fast and forgot to check for residual. RN A said she did not flush the tube before feeding Resident #1, which should be flushed to ensure the tube was patent. RN A said the water for the flush should be room temperature, not cold. RN A said she used cold water, which could cause discomfort for Resident #1, such as cramping and bloating. RN A said she was not trained on g-tube bolus feeding. RN A said she should have removed the dirty gloves, washed her hands, and donned (wore) a clean glove to prevent cross-contamination. RN A also said she should have donned the disposable gown because the resident was on enhanced precaution. During an interview on 09/06/24 at 6:19 p.m., The DON who said RN A should have gathered all the equipment she needed for bolus enteral feeding for Resident #1, disinfected the bedside table, put a protective barrier, and placed the equipment. She said RN A would then go and wash her hands and put on gloves. The DON said RN A should have listened to the bowel sounds, then checked the residual, and if it was higher than what it should be, then RN A should have held the feeding and called the NP. The DON said the rationale for checking the feeding was to make sure Resident #1 was not overfed and check the gastric content, and it also helped to adjust the feeding. The DON said the g tube should be flushed with 30 ml of water, depending on the quantity of water the physician ordered. The DON said RN A would flush with the amount of water prescribed. The DON said water for the flush should be at room temperature. The DON said if the water was cold, it would be a shock for Resident #1, thickening the feeding and clogging the tube. The DON said the water should agree with Resident #1's body temperature. The DON said RN A should have worn the disposable gown because Resident #1 was in an enhanced barrier precaution when she provided tube feeding for Resident. The DON said the nurse should not have used the plastic cup and covered the syringe because of infection control. The DON said if the germs from the plastic cup were introduced to the feeding, which would contaminate the feeding, then Resident #1 could get an infection. The DON said she monitored the nurses during rounding. The DON said she would look into RN A's training and send it an email. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of RN A's training signed and dated 08/07/2024, she was trained by the Nursing Department on infection control including PPE and hand hygiene. There was no specific training sent for bolus feeding. Record review of the facility policy on feeding tube management dated April 2022, revision April 2023 read in part . Observing the volume of fluid withdrawn from a tube at 4-hour intervals during continuous feedings or prior to each intermittent feeding may be helpful .

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F 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 4 (Resident #1) reviewed for pain management. -The facility failed to ensure that as a resident with cancer of the esophagus Resident #1's pain medications (Lyrica 75mg and Tramadol HCl 50mg) were available at the facility after he was admitted from a cancer treatment hospital. Resident #1 missed 6 doses of Lyrica on 09/04/2024 at 10pm, 09/05/2024 at 6am, 2pm and 10pm, and 09/06/2024 at 6am and 2pm and said he was in pain at a level 10 from 0 to 10 on 09/06/2024 - The facility failed to provide Resident #1 with prescribed pain management per Physician Orders dated 09/04/2024 -The facility failed to assess Resident #1 for pain on 09/05/2024 and 09/06/2024 per Physician Orders for every shift. -The facility failed to ensure RN B and LVN B followed the proper facility protocols when Resident #1's pain medication was not delivered and administered. This failure could cause residents on pain medications to experience unnecessary pain and serious harm. Findings included: Record review of Resident #1's facesheet dated 09/06/2024 reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His medical diagnoses included: malignant neoplasm of esophagus, Type 2 Diabetes Mellitus, Major Depressive Disorder, Anxiety Disorder, Hypertension, Atherosclerotic Heart Disease, and Dysphagia. Record review of the Resident #1's care plan dated 09/04/2024 revealed Resident #1 has the potential for pain. Interventions included: anticipate the resident's need for pain relief and respond immediately to any complaint of pain, monitor/document for probable cause of each pain. Record review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score was not completed. Record review of Resident #1's progress notes dated 9/6/20024 at 2:09 pm read in part . his BIMS score was a 13, indicating cognitive intactness . There were no documentation of Resident #1 taking any pain medication in the record. Record review of Resident #1's Physician Orders for September 2024, he was receiving the following: -Pain-Evaluate Pain every shift for Pain Evaluation with a start date 09/04/2024. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-Lyrica Oral Capsule 75MG (Pregabalin) Give 1 capsule via G-Tube three times a day for Pain, May open capsule and crush, mix with water with a start date 09/04/2024. -Tramadol HCL oral Tablet 50 MG Give 1 tablet via G-Tube every 6 hours as needed for pain. Record review of Resident #1's order audit report dated 09/06/2024 at 5:56pm, LVN A created an order for Lyrica Oral Capsule 75MG (Controlled Drug) on 09/04/2024 at 5:02pm. Further review of Resident #1's order audit report dated 09/06/2024 at 5:57pm, LVN A created an order for Tramadol Hcl (Controlled Drug) on 09/04/2024 at 4:34pm. Record review of Resident #1's September 2024 MAR dated 09/06/2024 at 7:41pm, the resident did not have pain evaluations for 09/05/2024 for the evening shift and 09/06/2024 for the day shift. Resident #1 did not have Lyrica for 09/04/2024 at 10pm, 09/05/2024 at 6am, 2pm, and 10pm, and 09/06/2024 at 6am, and was marked as administered at 2pm. Resident #1 had the following pain assessments completed: 09/04/2024 during admissions/evening shift with a pain level of 0, 09/05/2024 day shift with a pain level of 0, and on 09/06/2024 at 6:31pm with a pain level of 4 and received Tramadol HCl 50MG. Record review of Resident #1's hospital clinicals sent to the facility on [DATE] at 10:01am revealed he was taking Lyrica 75mg oral route scheduled every 12 hours and Tramadol 50mg every 6 hours as needed at the cancer treatment hospital. Interview with Resident #1 and FM W on 09/06/24 at 2:50 p.m., Resident #1 was attempted to talk but he lost his voice. FM W was in the room with Resident #1 and she said Resident #1 does lose his voice sometimes. FM W said Resident #1 had been in pain because he had not received his pain medication since being admitted to the facility. FM W said she had been asking the nurses when Resident #1 would get his pain medication. When Surveyor A was about to leave the room, Resident #1 was pointing to his throat and FM W said he was trying to say he was in pain. Observation of Resident #1's bolus feeding on 09/06/24 at 3:09 p.m., FM W asked RN A when she would administer pain medication to Resident #1 because he was in pain. RN A said she would check on the pain medication again when she finished administering the feeding. Interview with Resident #1 and FM W 09/06/24 at 4:00 p.m., Surveyor A assessed Resident #1's pain level on a scale of 1 to 10, and 1 being least and 10 being the most pain where you would rate your pain level. Resident #1 took some minutes strained with difficulty before he responded that his pain level was at 10. FM W said that the pharmacy had not delivered the medication. FM W said she had been asking the nurses and they kept telling her that they are working with the pharmacy. FM W said the nurse that worked yesterday told her most likely the medication would be sent today (09/06/24) by noon. FM W said she knew when Resident #1 was in pain because she had been with him for a long time. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with RN A on 09/06/24 at 4:22 p.m., RN A said Resident #1 had two pain medications. RN A said Lyrica was a scheduled medication and Tramadol was PRN and that Resident #1 had not received any of the pain medication. RN A said she called the pharmacy by 4:00 p.m. for both pain medications and the pharmacy said they did not have any order for those medications. RN A said she called the NP B at 4:08 p.m. , and NP B told RN A to text the medications to her, which RN A did. RN A said she had not worked with Resident #1 since he was admitted since today was her first day and FM W had asked for Resident #1's earlier and she had not checked to see if the pain medication was in the building until now. RN A said if Resident #1 did not get his pain medication, then the physician order was not followed. Interview with the DON on 09/06/24 at 5:32 p.m., the DON said Resident #1 has two pain medications. The DON said Resident #1 was admitted on the 09/04/24 and that both medications were ordered on 09/04/24 which meant Resident #1 was admitted with the medication. The DON said when the nurse verified Resident #1's medications with the physician or NP, then the physician would call in the medication to the pharmacy and the pharmacy would give the nurse a code to get the medication form the emergency kit (e-kit). The DON said the Lyrica was a scheduled medication for every 8 hours and Tramadol was PRN every 6 hours for pain. The DON said the initial dose for Lyrica would have been given to Resident #1 at 10:00 p.m. on the day of admission. Interview with the VPCO on 09/06/24 at 5:40 p.m., the VPCO said if the medication was not available, the nurses should have called the physician and asked if there was an alternative medication and notify the physician Resident #1 medication script had not been faxed to the pharmacy. The VPCO said the nurses should have notified the DON that Resident #1 pain medication was not delivered, and the DON would have followed up with the physician and pharmacy too. Interview with the DON on 09/06/24 at 6:04 p.m., the DON said RN A did not notify her that Resident #1 had not received his pain medication from the pharmacy nor that the medication had not been administered to Resident #1. The DON said if Resident #1 did not receive his pain medication he would be in pain. The DON said the medication was given on 09/05/24 according to the MAR. Interview with the VPCO on 09/06/24 at 6:13 p.m., the VPCO said the system was broken down when the nurses did not follow the facility protocol by not notifying the physician and not asking for physician to send the script to the pharmacy and or to receive an alternate pain medication. The VPCO said Resident #1 would be in pain until the facility was able to address it (obtained Resident #1 medication and administered the medication). (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with NP B on 09/06/24 at 7:26 p.m., NP B said she was the person who verified Resident #1's medication on admission. NP B said Resident #1 was either admitted in the evening or at night and she did not fax Resident #1's medication until the next day when she went to her office because she did not have access to her communication system in order to fax the medication after she verified the medications. NP B said the facility nurse told her Resident #1 was not in pain on admission. NP B said the nurses would have let her know that the medication was not in the building, and they would have had a three-way call to the pharmacy, and pharmacy would give the nurse a code for the pain medication which the nurses would use and get the pain medication from the e-kit. NP B said she did not remember if the nurses had called her before 09/06/24. NP B said RN A called her today (09/06/24) at 4:00 p.m. and told her that Resident #1's pain medications was not in the building, and she told her to call the pharmacy for the pain medications. NP B said RN A called her back and told NP B that the pharmacy said they have not received the pain medication prescription, that was when she said did a three way call around 4:30 p.m., and she told the pharmacy to give RN A the code to get the pain medication from the E-kit. Interview with RN A on 09/06/24 at 8:01 p.m., RN A said she made a mistake by signing off on the Lyrica. RN A said she gave the pain medication Tramadol at 6:31 p.m. after she had a three-way call with pharmacy and NP B. RN A said she did not get report from the previous nursing shift that the resident medication was not delivered. RNA said FM had been telling her Resident #1 was in pain during her shift. RN A said Resident #1 could not tell her because the resident had Aphasia (difficulty talking). RN A said she did not notify the DON because she was trying to find out how to get the pain medication. RN A said when the FM was asking for the pain medication, she thought FM was referring to other medications. Telephone interview with RN B on 09/06/24 at 8:29 p.m., RN B said the nurse she took over from told her that she called the doctor, and the doctor would call it in the pain medication to the pharmacy. RN B said when the pharmacy brought Resident #1 medication on 09/04/2024 Resident #1's pain medications were not among his medications. RN B said she called the pharmacy, and they told her they did not have the triplicate paperwork to be able to provide the pain medications. RN B said she did not call the doctor on 09/04/24. RN B said when she came back on 09/05/24, she called the pharmacy and reported to the person on-call that the facility had not received Resident #1's pain medications. The on-call person told RN B that said she would relate it to the pharmacy. RN B said she went about doing her work and she did not call the doctor or notified the DON or documented the calls she made to the pharmacy. RN B said FM was always in Resident #1's room and would ask for Resident #1's pain medication. RN B said she did not know what the facility protocol was if Resident #1's pain medications were not delivered. RN B said she told the morning nurse (RN A) on 09/06/24 that Resident #1 pain medication did not come. She said she did not know she did not document on the MAR about Resident #1 pain assessment. RN B said the DON monitors nurses during rounding. Telephone interview with LVN C on 09/07/24 at 9:33 a.m., LVN C said FM told her that Resident #1 was in pain, and she said told FM W about 4 or 5 times during her shift that the pharmacy had not brought the pain medications. LVN C said the pain medications did not come in before she left her shift and she had not returned to work since then. LVN C said she was a new staff, and she did not know the facility protocol if a resident missed medications or if the medication was not delivered. LVN C said she told the DON on 09/05/24 that Resident #1's pain medication was not delivered, and she could not remember what the DON said. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676454	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Katy, LLC	1222 Park West Green Drive Katy, TX 77493

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of the facility's Pharmacy Services policy last revised or reviewed in May 2024 reflected the facility's overall goal of the pharmaceutical services system is to ensure safe and effective use of medications by providing routine and emergency drugs and biologicals to our residents or obtain them through contractual arrangements .that ensure accurate acquiring, receiving, dispensing and administration of all drugs .to meet the needs of each resident. Record review of the facility's Pain Management policy last revised or reviewed May 2023 stated, Each and every resident has a right to the assessment and management of pain. The policy then goes on and discussed chronic pain, which included malignant, cancerous chronic pain, which may be due to tumor progression, invasive procedures infection, physical limitations, may be experienced by the resident as chronic and acute pain and that the facility should investigate immediately any new pain. It further stated that, if the resident has been identified with pain, the resident will undergo reassessment of pain at least once per shift and before and after every pain control mechanism employed by the resident's care providers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

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F 0755

Level of Harm - Actual harm

Residents Affected - Some

Note: The nursing home is disputing this citation.

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 48923

Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 (Resident #1) residents reviewed.

-The facility failed to ensure that as a resident with cancer of the esophagus Resident #1's Lyrica and Tramadol were available for administration from 09/04/2024 at 10pm to 09/06/2024 at 2pm according to Physician Orders started on 09/04/2024 when Resident #1's nurses knew the pharmacy did not have the prescription for the pain medications but the nurses did not intervene even after Resident #1's representatives requested his pain medications

This deficient practice could place residents at risk for adverse effects by not receiving the therapeutic effects of the medication.

Findings included:

Record review of Resident #1's face sheet dated 09/06/2024 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His medical diagnoses included: malignant neoplasm of esophagus, Type 2 Diabetes Mellitus, Major Depressive Disorder, Anxiety Disorder, Hypertension, Atherosclerotic Heart Disease, and Dysphagia.

Record review of the Resident #1's care plan dated 09/04/2024 revealed Resident #1 has the potential for pain. Interventions included: anticipate the resident's need for pain relief and respond immediately to any complaint of pain, monitor/document for probable cause of each pain.

Record review of Resident #1's progress notes dated 9/6/20024 at 2:09 pm read in part . his BIMS score was a 13, indicating cognitive intactness . There were no documentation of Resident #1 taking any pain medication in the record.

Record review of Resident #1's Physician Orders for September 2024, he was receiving the following:

-Pain-Evaluate Pain every shift for Pain Evaluation with a start date 09/04/2024

-Lyrica Oral Capsule 75MG (Pregabalin) Give 1 capsule via G-Tube three times a day for Pain, May open capsule and crush, mix with water with a start date 09/04/2024

-Tramadol Hcl oral Tablet 50 MG Give 1 tablet vi G-Tube every 6 hours as needed for pain

Record review of Resident #1's order audit report dated 09/06/2024 at 5:56pm, LVN A created an order for Lyrica Oral Capsule 75MG (Controlled Drug) on 09/04/2024 at 5:02pm. Further review of Resident #1's order audit report dated 09/06/2024 at 5:57pm, LVN A created an order for Tramadol Hcl on 09/04/2024 at 4:34pm.

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's MAR for September 2024 dated 09/06/2024 at 7:41pm, the resident did not have pain evaluations for 09/05/2024 for the evening shift and 09/06/2024 for the day shift. Resident #1 did not have Lyrica for 09/04/2024 at 10pm, 09/05/2024 at 6am, 2pm, and 10pm, and 09/06/2024 at 6am, and was marked as administered at 2pm. Resident #1 had the following pain assessments completed: 09/04/2024 during admissions/evening shift with a pain level of 0, 09/05/2024 day shift with a pain level of 0, and on 09/06/2024 at 6:31pm with a pain level of 4 and received Tramadol HCl 50MG. Record review of Resident #1's hospital clinicals sent to the facility on [DATE] at 10:01am reflected he was taking Lyrica 75mg oral route scheduled every 12 hours and Tramadol 50mg every 6 hours as needed at the cancer treatment hospital. Interview with Resident #1 and FM W on 09/06/24 at 2:50 p.m., Resident #1 was attempted to talk but he lost his voice. FM W was in the room with Resident #1 and she said Resident #1 does lose his voice sometimes. FM W said Resident #1 had been in pain because he had not received his pain medication since being admitted to the facility. FM W said she had been asking the nurses when Resident #1 would get his pain medication. When the surveyor was about to leave the room, Resident #1 was pointing to his throat and FM W said he was trying to say he was in pain. Observation of Resident #1's bolus feeding on 09/06/24 at 3:09 p.m., FM W asked RN A when she would administer pain medication to Resident #1 because he was in pain. RN A said she would check on the pain medication order after she finished administering the feeding. Interview with Resident #1 and FM W 09/06/24 at 4:00 p.m., Surveyor A assessed Resident #1's pain level on a scale of 1 to 10, and 1 being least and 10 being the most pain where you would rate your pain level. Resident #1 took some minutes strained with difficulty before he responded that his pain level was at 10. FM W said that the pharmacy had not delivered the medication. FM W said she had been asking the nurses and they kept telling her that they are working with the pharmacy. FM W said the nurse that worked yesterday told her must likely the medication would be sent today (09/06/24) by noon. FM W said she knew when Resident #1 was in pain because she had been with him for a long time. Interview with RN A on 09/06/24 at 4:22 p.m., RN A said Resident #1 had two pain medications. RN A said Lyrica was a scheduled medication and Tramadol was PRN and that Resident #1 had not received any of the pain medication. RN A said she called the pharmacy by 4:00 p.m. for both pain medications and the pharmacy said they did not have any order for those medications. RN A said she called the NP B at 4:08 p.m. , and NP B told RN A to text the medications to her, which RN A did. RN A said she had not worked with Resident #1 since he was admitted since today was her first day and FM W had asked for Resident #1's earlier and she had not checked to see if the pain medication was in the building until now. RN A said if Resident #1 did not get his pain medication, then the physician order was not followed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Katy, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1222 Park West Green Drive Katy, TX 77493	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with the DON on 09/06/24 at 5:32 p.m., the DON said Resident #1 has two pain medications. The DON said Resident #1 was admitted on the 09/04/24 and that both medications were ordered on 09/04/24 which meant Resident #1 was admitted with the medication. The DON said when the nurse verified Resident #1's medications with the physician or NP, then the physician would call in the medication to the pharmacy and the pharmacy would give the nurse a code to get the medication form the emergency kit (e-kit). The DON said the Lyrica was a scheduled medication for every 8 hours and Tramadol was PRN every 6 hours for pain. The DON said the initial dose for Lyrica would have been given to Resident #1 at 10:00 p.m. on the day of admission. Interview with the VPCO on 09/06/24 at 5:40 p.m., the VPCO said if the medication was not available, the nurses should have called the physician and asked if there was an alternative medication and notify the physician Resident #1 medication script had not been faxed to the pharmacy. The VPCO said the nurses should have notified the DON that Resident #1 pain medication was not delivered, and the DON would have followed up with the physician and pharmacy too. Interview with the DON on 09/06/24 at 6:04 p.m., the DON said RN A did not notify her that Resident #1 had not received his pain medication from the pharmacy nor that the medication had not been administered to Resident #1. The DON said if Resident #1 did not receive his pain medication he would be in pain. The DON said the medication was given on 09/05/24 according to the MAR. Interview with the VPCO on 09/06/24 at 6:13 p.m., the VPCO said the system was broken down when the nurses did not follow the facility protocol by not notifying the physician and not asking for physician to send the script to the pharmacy and or to receive an alternate pain medication. The VPCO said Resident #1 would be in pain until the facility was able to address it (obtained Resident #1 medication and administered the medication). Interview with NP B on 09/06/24 at 7:26 p.m., NP B said she was the person who verified Resident #1's medication on admission. NP B said Resident #1 was either admitted in the evening or at night and she did not fax Resident #1's medication until the next day when she went to her office because she did not have access to her communication system in order to fax the medication after she verified the medications. NP B said the facility nurse told her Resident #1 was not in pain on admission. NP B said the nurses would have let her know that the medication was not in the building, and they would have had a three-way call to the pharmacy, and pharmacy would give the nurse a code for the pain medication which the nurses would use and get the pain medication from the e-kit. NP B said she did not remember if the nurses had called her before 09/06/24. NP B said RN A called her today (09/06/24) at 4:00 p.m. and told her that Resident #1's pain medications was not in the building, and she told her to call the pharmacy for the pain medications. NP B said RN A called her back and told NP B that the pharmacy said they have not received the pain medication prescription, that was when she said did a three way call around 4:30 p.m., and she told the pharmacy to give RN A the code to get the pain medication from the E kit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
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F 0755 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with RN A on 09/06/24 at 8:01 p.m., RN A said she made a mistake by signing off on the Lyrica. RN A said she gave the pain medication Tramadol on 09/06/2024 at 6:31 p.m. after she had a three-way call with pharmacy and NP B. RN A said she did not get report from the previous nursing shift on 09/05/2024 from 7pm to 7am who would have been LVN C that the resident medication was not delivered. RNA said FM W had been telling her Resident #1 was in pain during her shift. RN A said Resident #1 could not tell her because the resident had Aphasia (difficulty talking). RN A said she did not notify the DON because she was trying to find out how to get the pain medication. RN A said when FM W was asking for the pain medication, she thought FM was referring to other medications. Telephone interview with RN B on 09/06/24 at 8:29 p.m., RN B said the nurse she took over from told her that she called the doctor, and the doctor would call in the pain medication to the pharmacy. RN B said when the pharmacy brought Resident #1 medication on 09/04/2024 Resident #1's pain medications were not among his medications. RN B said she called the pharmacy, and they told her they did not have the triplicate paperwork to be able to provide the pain medications. RN B said she did not call the doctor on 09/04/24. RN B said when she came back on 09/05/24, she called the pharmacy and reported to the person on-call that the facility had not received Resident #1's pain medications. The on-call person told RN B that said she would relate it to the pharmacy. RN B said she went about doing her work and she did not call the doctor or notified the DON or documented the calls she made to the pharmacy. RN B said FM W was always in Resident #1's room and would ask for Resident #1's pain medication. RN B said she did not know what the facility protocol was if Resident #1's pain medications were not delivered. RN B said she told the morning nurse (RN A) on 09/06/24 that Resident #1 pain medication did not come. RN B said she did not know she did not document on the MAR about Resident #1 pain assessment. RN B said the DON monitors nurses during rounding. Telephone interview with LVN C on 09/07/24 at 9:33 a.m., LVN C said FM told her that Resident #1 was in pain, and she said told FM W about 4 or 5 times during her shift that the pharmacy had not brought the pain medications. LVN C said the pain medications did not come in before she left her shift and she had not returned to work since then. LVN C said she was a new staff, and she did not know the facility protocol if a resident missed medications or if the medication was not delivered. LVN C said she told the DON on 09/05/24 that Resident #1's pain medication was not delivered, and she could not remember what the DON said. Record review of the facility's Pharmacy Services policy last revised or reviewed in May 2024 reflected the facility's overall goal of the pharmaceutical services system is to ensure safe and effective use of medications by providing routine and emergency drugs and biologicals to our residents or obtain them through contractual arrangements .that ensure accurate acquiring, receiving, dispensing and administration of all drugs .to meet the needs of each resident. Record review of the facility's Pain Management policy last revised or reviewed May 2023 stated, Each and every resident has a right to the assessment and management of pain. The policy then goes on and discussed chronic pain, which included malignant, cancerous chronic pain, which may be due to tumor progression, invasive procedures infection, physical limitations, may be experienced by the resident as chronic and acute pain and that the facility should investigate immediately any new pain. It further stated that, if the resident has been identified with pain, the resident will undergo reassessment of pain at least once per shift and before and after every pain control mechanism employed by the resident's care providers.

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NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Katy, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1222 Park West Green Drive Katy, TX 77493	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review, the facility failed to maintain an infection prevention control program that included standard and transmission-based precautions to be followed to prevent spread of infections and hand hygiene procedures to be followed by 2 of 4 staff (CNA A and RN A) involved in direct resident contact. 1. CNA A left a waste bag on the floor outside a resident's room without disposing of it in a hygienic manner on 08/19/2024. 2. The facility failed to ensure RN A followed proper infection control and hand washing procedure during G - tube bolus feeding for Resident #1 on 09/06/2024 3. The facility failed to ensure Resident #1 Foley tubing was not touching the floor during observations on 09/06/2024 This failure could affect all residents by causing spread of disease in a facility due to not following infection control procedures. Findings included: 1. Observation on 8/19/2024 at 1:03am, there was a small, clear bag of trash outside of room [ROOM NUMBER]. Interview with LVN D on 8/19/2024 at 1:03am, who said that the bag was not there when she rounded before but that the risk to residents of having trash left on the floor would be infection control. Interview with CNA A on 08/19/2024 at 1:45am, who said that she left the bag on the floor because she had to go see another resident who pressed their call light. CNA A said the bag should not have been there due to infection control. CNA A said she had infection control in-services. Interview with the DON on 9/6/2024 at 5:01pm, she said she expected that CNAs throw trash away and not leave it on the floor. She said a risk to residents of used trash bags being on the floor would be infection control. 2. Record review of Resident #1's face sheet dated 09/06/2024 revealed he was an [AGE] year-old male admitted to the facility on [DATE]. Resident#1 had diagnoses which included: malignant neoplasm of esophagus (cancer that forms in the of the esophagus), Type 2 Diabetes Mellitus (body cannot produce enough insulin or cannot use insulin properly), Hypertension (condition where the pressure in your blood vessels is always high), Atherosclerotic Heart Disease (thickening or hardening of the arteries), and Dysphagia(swallowing). Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score was not completed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ignite Medical Resort Katy, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 1222 Park West Green Drive Katy, TX 77493	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes dated 9/6/20024 read in part . his BIMS score was a 13, indicating cognitive intactness . Record review of Resident #1's care plan initiated on 09/04/24 revealed resident requires enteral nutrition. Interventions: listen to lung sounds as ordered. It further revealed the resident has a urinary catheter. Interventions: Resident on Enhanced Barrier Precautions. Record review of Resident #1's order summary report for September 2024 read in part . Nutren 1.5 give 250 ml or 1 can 4 times a day per G- tube four times a day for Supplement dated 09/04/24 . Record review of Resident #1's MAR dated July 2024 read . Enteral Feed Order every shift for Routine Care Check enteral tube placement via aspiration &auscultation immediately after insertion, before each feeding / flush, before medication administration, before performing gastric residual check &at least every 8 hours . During an observation on 09/06/24 at 3:09 p.m., during Resident #1's bolus feeding, RN A took a pair of gloves from her cart and donned the gloves, and she took a 250 ml box of feeding formula and two clear plastic cups; one had cold water, and the order was empty RN A did not Donn a disposal gown. RN A took the stethoscope, which was hanging around her neck, and assessed Resident #1's abdominal quadrants without disinfecting the bell of the stethoscope. When RN A administered the feeding, she covered the syringe with the plastic cup that had the feeding because Resident #1 was trying to cough. RN A flushed with 30 ml of cold water after feeding. RN A wore the same gloves and opened the restroom door, turned on the water faucet, rinsed the syringe, turned off the water faucet, took the paper tower from the paper tower folder, and dried the syringe. RN A returned to Resident #1's bedside table, took the plunger, inserted it back into the syringe, and placed it back into Resident #1's nightstand, still wearing the same gloves. During an interview on 09/06/24 at 3:40 p.m., RN A said Resident #1's bedside table should be disinfected, and a barrier placed Resident #1 bolus feeding and syringe on the table. RN A said she should have removed the dirty gloves, washed her hands, and donned a clean glove to prevent cross-contamination. RN A also said she should have donned the disposable gown because the resident was on enhanced precaution. During an interview on 09/06/24 at 6:19 p.m., The DON said RN A should have gathered all the equipment she needed for bolus feeding for Resident #1, disinfected the bedside table, put a protective barrier, and placed the equipment. The DON said RN A would then go and wash her hands and put on gloves. The DON said RN A should have worn the disposable gown because Resident #1 was in an enhanced barrier precaution when she provided tube feeding for Resident. The DON said the nurse should not have used the plastic cup and covered the syringe during G tube feeding because of infection control. The DON said if the germs from the plastic cup were introduced to the feeding, which would contaminate the feeding, then Resident #1 could get an infection. The DON said she monitored the nurses during rounding. 2. Record review of Resident #1's care plan initiated on 09/04/24 revealed Resident #1 has a urinary catheter. Interventions: check placement of tubing each shift. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's order summary report for September 2024 read in part . Nurse to update the size of foley catheter 16 FR/ 10 cc balloon upon admission active date 09/04/2024 . 3. During an observation of Resident #1's care on 09/06/24 at 3:09 p.m., revealed Resident #1's foley tubing was touching the floor. During an observation of Resident #1's care on 09/06/24 at 3:35 p.m. revealed RN A observed the foley tubing was lying on the floor. During an interview on 09/06/24 at 3:47 p.m., RN A said Resident #1's foley tubing was lying on the floor. RN A said the tubing should not be touching the floor because microorganisms could enter Resident #1's urinary system and cause a urinary tract infection. RN A said she had no training or skills check-off for caring for a foley. RN A said the nurse monitored the aides during rounding, and the DON monitored the nurses when she rounded. During an interview on 09/06/24 at 3:55 p.m., CNA M said she assisted the PTA R when he transferred Resident #1 from the bed to the wheelchair around 12:00 p.m., and PTA R hung the foley bag on the wheelchair. CNA M said Resident #1's foley tubing should not touch the floor because of infection control. CNA M said Resident #1 could get an infection, but she did not know what type of infection because she was not a doctor. CNA M said she had training and in-service on infection control, and the nurse monitored the aides when she made rounds. During an interview on 09/06/24 at 6:38 p.m., The DON said Resident #1 foley tubing was not supposed to touch the floor because of infection control and resident #1 could get infection and the tubing could get kinked if Resident #1 rolled over the tubing with his wheelchair. The DON said the nurses monitored the aides, and she monitored the nurses. During an interview on 09/08/24 at 2:02 p.m., PTA R said he assisted the OT and CNA M when Resident #1 was transferred to the wheelchair on 09/06/24, and it was around lunchtime. PTA R said the foley bag should be placed on the cross bar under the wheelchair. PTA R said CNA M placed the bag under the wheelchair. He said he was unsure if the foley tubing was touching the floor after Resident #1 was transferred to the wheelchair. PTA R said the foley tubing should not touch the floor because the tube could become contaminated with the germs on the floor, and Resident #1 could get an infection. Record review of the facility policy on cauterization of urinary bladder dated November 2018, revision date 04/2023 read in part . procedure #14 . Hang collection bag appropriately to the side of the bed, keeping it below the bladder and off the floor . Record review of the facility's Infection Control policy last revised or reviewed in May 2024revealed that the facility will facilitate safe care of all residents and staff with known or suspected communicable disease by establishing and maintaining and infection prevent and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections, including standard and transmission-based precautions and hand hygiene procedures to be followed by staff involved in direct resident contact.