STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745017	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge of Saginaw Health and Wellness	848 W McLeroy Blvd Saginaw, TX 76179

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure the resident had the right to a safe, clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safely for one (Resident #30) of six residents reviewed for resident rights. The facility failed to ensure Resident #30's wheelchair was free of debris. This failure could place residents at risk of not having a safe, clean, comfortable, and homelike environment. Findings included: Record review of Resident #30's Admission Record dated 09/12/24 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease without dyskinesia (neurodegenerative disease that affects both motor and nonmotor systems of the body), bilateral primary osteoarthritis of hip (inflammation and injury to a joint causing a breakdown of cartilage tissue), difficulty in walking, muscle weakness, lack of coordination, unsteadiness on feet, wedge compression fracture of vertebra (when one side of vertebra collapse), and wedge compression fracture of lumbar vertebra (collapse of a vertebra, due to weakening of the vertebra). Record review of Resident #30's quarterly MDS assessment, dated 08/31/24, reflected a BIMS score of 5 indicating severe cognitive impairment. His Functional Status evaluation indicated he required assistance with wheelchair, dependent on staff for toileting, substantial assistance with dressing and personal hygiene. Record review of Resident #30's undated care plan, reflected he had an ADL self-care deficit, with goal to include current level of function, interventions including Resident to have bilateral lateral support placed in wheelchair daily. Resident has the potential for skin impairment related to decreased mobility, incontinence. Goal: Resident will have no skin breakdown related to incontinence. Interventions include to reposition resident on CNA rounds. Observation on 09/10/24 at 3:20 PM revealed Resident #30 sitting in his wheelchair. The wheelchair was observed to be dirty with visible debris and dirt on his wheelchair. (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: 745017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER The Lodge of Saginaw Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 848 W McLeroy Blvd Saginaw, TX 76179	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/11/24 at 12:20 PM revealed Resident #30 sitting in his wheelchair, the wheelchair was observed to be dirty with visible debris and dirt on his wheelchair. Interview and observation on 09/12/24 at 11:19 AM with LVN A revealed if the aides were to notice anything wrong with resident's wheelchair, they were to alert the nurse, and depending on what was reported, the nurse will alert the housekeeping supervisor. Observation of Resident #30's wheelchair revealed it was dirty with chucks of debris on both sides of the resident's seat. LVN A reported aides were supposed to wipe down resident wheelchairs if they were dirty. LVN A stated aides were responsible for keeping wheelchairs as clean as possible. LVN A stated Resident #30 was placed at risk of infection when his wheelchair was not wiped down or kept clean. Interview and observation on 09/12/24 at 12:17 PM with CNA C revealed she was currently working with Resident #30, CNA C stated she assisted Resident #30 with transfers in and out of his wheelchair. Observation of Resident #30's wheelchair revealed it was dirty with chunks of debris on both sides of the resident's seat. CNA C stated she would normally look at wheelchairs and clean if needed. CNA C stated it was been busy, she did not notice Resident#30's wheelchair was not clean. CNA A stated she did not know of any risk to residents if their wheelchair was dirty, not cleaned, or wiped down. According to CNA C, Resident #30 did not have any pressure ulcers or open wounds. Interview on 09/12/24 at 3:00 PM with the ADON revealed the overnight nursing team should have been checking resident wheelchairs every night to ensure they were clean. The ADON stated her expectations were that nursing staff did a quick wipe down to ensure wheelchairs were clean and operating appropriately. The ADON stated nurses and nurse aides were responsible to assist residents with clean wheelchair and environments, and not doing so, placed residents at risk of dignity issues and not having a properly functioning wheelchair which could cause hazards to the resident. Interview on 09/12/24 at 3:24 PM with the DON revealed her expectations were for nursing staff to ensure resident wheelchairs were wiped down and clean. The DON stated there was no specific time to clean them; it should be done throughout the day. The DON stated, if needed, nursing staff could report to the maintenance department to hose them down so they could be cleaned. The DON stated not keeping wheelchairs cleaned could place residents at risk of hygiene issues and could infect or re-infect residents with illness and adverse reactions. Record review of the facility's policy Hazardous Areas, Devices and Equipment, revised July 2017, reflected: All hazardous areas, devices and equipment in the community will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to the following: a. Equipment and devices that are left unattended or are malfunctioning. b. Devices and equipment that are improperly used or poorly maintained.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42859

Based on observation, interview, and record review, the facility failed to ensure a resident 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 based on the comprehensive assessment for 1 of 4 residents (Resident #22) reviewed for pressure ulcers.

The facility failed to ensure the DTI on Resident #22's right and left buttocks across the sacrum was covered with a dressing.

This failure could place residents at risk of pain and lead to systemic infections causing harm for residents.

Findings included:

Review of Resident #22's face sheet dated 09/12/24 reflected the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 had diagnoses which included diabetes (high blood sugar) and other specified non-inflammatory disorders of vulva and perineum.

Review of Resident #22's quarterly MDS assessment dated [DATE], reflected Resident #22 had a BIMS score of 06, reflecting the resident's cognition was severely impaired. She was at risk of developing pressure ulcers. The IDT was from a blister.

Review of Resident #22's care plan revised date 03/11/24 reflected: Focus: The resident has actual impairment to skin integrity of the right buttocks (blister) 8/19/24 DTI of the sacrum. Goal: The resident will maintain or develop clean and intact skin by the review date. Interventions: Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal sign and symptoms of infection, maceration etc. to MD. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.

Review of Resident #22's physician orders dated 08/19/24 reflected: Clean wound on left and right buttock/sacrum with normal saline or wound cleanser. Dry. Apply a hydrocolloid bandage and change [Monday-Wednesday-Friday] and as needed one time a day every Mon, Wed, Fri.

Observation with LVN G on 09/12/24 at 10:16 AM of the DTI on Resident #22's right and left buttocks wound did not have a dressing on it. LVN G stated she was not aware Resident #22 did not have a dressing on. Observed Resident #22's brief to be wet. No signs of infection noted.

Observation and interview on 09/12/24 at 10:30 AM revealed Resident #22 was lying in bed. Resident #22 stated she was doing well. Resident #22 stated she developed some blisters on her buttocks, and they turned into wounds. Resident #22 stated she was not aware the dressing was off.

(continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/12/24 at 10:39 AM with CNA D revealed she was the CNA assigned to Resident #22. She stated between 6:00 AM - 6:30 AM, she provided incontinenc care to Resident #22, and she noticed the resident did not have a dressing on her wound. She stated she knew she was supposed to notify the nurse or the treatment nurse, but she did not, it slipped her mind, and she forgot to notify the nurse. She stated Resident #22 did not complain of pain. CNA D stated she should have notified the nurse. She stated the risk of not having a dressing on would be infection. Interview on 09/12/24 at 2:43 PM with LVN G revealed Resident #22 had a physician's order to cleanse and cover the wound three days in a week Monday Wednesday and Friday. She stated she was not made aware that Resident #22's dressing had come off. She stated when she completed wound care yesterday (09/11/24) on Resident #22, she had applied a dressing over it. She stated her expectations were for the nurses to monitor the dressing every shift and if the dressing came off, they had PRN treatment orders to follow. She stated the potential risk if the dressing comes off would be a decline in the wound status and infections. She stated she had not done training to staffs because she was newly hired. Interview on 09/12/24 at 3:44 PM with the DON revealed her expectations were for her staff to follow orders and as needed orders. If the dressing came off when completing perineal care, the aides were to notify the nurse, and the nurses were to apply a new dressing. The DON stated she had not completed in-services on wound care. She stated the risk of not having a dressing could lead to an infection and wound margins increasing. Review of facility policy Personal Care revised February 2018, reflected the following: 6. If a splint or dressing or patch (medication) comes off, gets wet or soiled report this to the nurse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible to prevent accidents for 1 of 1 resident (Resident#87) reviewed for hazards. The facility failed to ensure LVN H discarded sharps in the sharp containers. This failure placed residents at risk of being exposed to contaminated sharps and possible bloodborne pathogens. Findings included: Record review of Resident #87's face sheet, dated 09/12/24, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #87's diagnoses included major depressive disorders (common mental disorder that causes a persistent depressed mood and loss of interest in activities for long periods of time) and gastrostomy status (a surgical opening into the stomach for nutritional support). Review of Resident #87's quarterly MDS assessment, dated 06/01/24, revealed the resident had intact cognition with a BIMS score of 13. Observation on 09/11/24 at 7:51 AM with LVN H checking the blood sugar for Resident #87 revealed she sanitized her hands, put on gloves, and explained the procedure to Residnet#87. She cleansed the finger for Residnet#87 with alcohol wipes and pricked the finger to get the blood sample. She was observed discarding the sharps (a lancet) in the trash can. She removed gloves and washed hands. She prepared Insulin Lispro 4 units after cleansing the tip of the pen with alcohol pad and connected the needle. She sanitized, put on gloves, and went to the bed side. She administered insulin on the right deltoid (the muscle forming the rounded contour of the human shoulder). She removed the needle and trashed it in the trash can. She removed gloves washed hands and put on new gloves and disinfected the glucometer and left to dry. Interview on 09/11/24 at 9:05 AM with LVN H revealed she wrapped sharps with gloves and trashed in the trash can. She stated she was aware she was supposed to discard in the sharp container either in Resident #87's room or outside in the nurse's medication cart sharp container. LVN H stated she knew better because she was once an infection control preventionist for the facility. She stated the risk was other staff being stuck and could lead to spread of infection. Interview on 09/12/24 at 11:52 AM with ADON B revealed her expectation was that staff discarded all sharps in the sharp's container. She stated the risk would be other staff being stuck and contamination. She stated management staff were responsible of ensuring the nurses were following safe sharp disposal protocol. She stated she had not done training on sharps disposal. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/12/24 at 03:37 PM with the DON revealed her expectation was for the staff to discard all sharps in the sharp containers. The DON stated the management were responsible for monitoring other staff to ensure the sharps were being discarded in sharp containers. She stated the risk was a person could get injured by being stuck by the needles. Review of the facility's policy revised January 2012 titled Sharps Disposal reflected: " 1.Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers. 2.Contaminated sharps will be discarded into containers that are: a. closable. b. Puncture resistant. c. Leakproof on sides and bottom. d. Labeled or color-coded in accordance with our established labeling system; and e. Impermeable and capable of maintaining impermeability through final waste disposal.

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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** 44937 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 one (Resident #75) of four residents reviewed for quality of care. The facility failed to ensure Resident #75's catheter bag was not on the floor. This deficient practice could place residents at risk for UTIs and other infections. Findings included: Record review of Resident #75's face sheet, dated 09/12/24, reflected an admitted [DATE], and re-admitted [DATE]. Resident #75 had diagnosis which included encounter for fitting and adjustment of urinary device (catheter), symptoms and signs concerning food and fluid intake, chronic kidney disease stage 3 (mild to moderate kidney damage), hypertensive heart (complications of high blood pressure) and chronic kidney disease (gradual loss of kidney function) with heart failure. Record review of Resident #75's quarterly MDS assessment, dated 06/24/24, reflected a BIMS score of 6 indicating severe cognitive impairment. Her Functional Status evaluation indicated she was dependent on staff for toileting, substantial assistance with dressing and personal hygiene. Resident #75 presented with an indwelling catheter. Record review of Resident #75's care plan revealed Resident #75 had an ADL self-care performance deficit related to Impaired balance, Limited Mobility, Musculoskeletal impairment with a goal to maintain current level of function. Interventions included requiring 1 staff assist for toileting. Resident has a Foley Catheter due to Pressure Ulcer stage 4 to the sacral area with goal to be/remain free from catheter-related trauma, interventions included CATHETER: resident has 16 French Foley catheter, Position catheter bag and tubing below the level of the bladder and away from entrance room door, Check tubing for kinks each shift. Monitor and document intake and output as per facility policy. Monitor for signs and symptoms of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Observation on 09/10/24 at 1:57 PM revealed Resident #75's catheter bag was leaning on the floor while hanging from the lowest part of the bed. The catheter bag was not securely connected to the bedframe allowing it to lay partially on a mattress and the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/12/24 at 10:32 AM with CNA D revealed she usually did rounds on residents every two hours and with Resident #75 she was responsible to empty her catheter bag at the end of the shift. CNA D stated if she saw any concerns with Resident #75's catheter, should report to the nurse on duty, and the nurse would then change the bag if needed. CNA D stated she had worked with Resident #75 during the week, that she usually worked the hall and knew to have Resident #75's bag hanging from a low position of the bed, not touching the floor. CNA D stated she had not observed any concerns with the catheter bag touching the floor. CNA D stated if Resident #75's bag was to touch the floor it would place Resident #75 at risk of infection. Observation and interview on 09/12/24 at 10:47 AM revealed Resident #75's catheter bag was on the floor. Observation and interview on 09/12/24 at 10:58 AM with LVN B revealed Resident #75's catheter bag was on the floor. LVN B stated CNAs were responsible for ensuring catheter bags were not on or touching the floor. LVN B stated the aide may not have checked the bag after incontinent care or while repositioning Resident #75. LVN B stated she expected the aides to ensure, after incontinent care, that they were ensuring the catheter bag was hanging at a low position without touching the floor. LVN B reposition the catheter bag off the floor, and stated having the bag on the floor placed Resident #75 at risk for infection. Interview on 09/12/24 at 2:53 PM with the ADON revealed she was ultimately responsible for ensuring the nursing staff working with Resident #75 were checking her catheter bag for a privacy cover, not touching the floor, dragging on the floor, not too high, or ensuring the line was draining properly at least two times per shift. The ADON stated not doing so, could place Resident #75 at risk of the catheter pulling out which could hurt, knotting up which could send the fluid back up towards the resident, infection, and ultimately dignity issues. Interview on 09/12/24 at 3:24 PM with the DON revealed all nursing staff were responsible to ensure catheter bags were secured off the floor. The DON stated not doing so could create adverse effects and infection for Resident #75. The DON stated in-services had been completed, however was not able to recall the time or date of last in-service. Record review of the facility policy, dated September 2014, labeled Catheter Care, Urinary, revealed the purpose of this procedure is to prevent catheter-associated urinary tract infections. Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed. Use standard precautions when handling or manipulating the catheter, tubing, or drainage bag. Be sure the catheter tubing and drainage bag are kept off the floor.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs for 1 of 3 residents (Resident #87) reviewed for pharmacy services. 1. The facility failed to ensure LVN H administered Resident #87's Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 mg 1 capsule via gastrostomy tube, in the morning related to mood on 09/11/24 at 7:51 AM. 2. The facility failed to ensure LVN H checked the residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding) before administering medication through gastrostomy on Resident #87. These failures could place residents at risk of medical complications. Findings included: Record review of Resident #87's face sheet, dated 09/12/24, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #87's diagnoses included major depressive disorders and gastrostomy status. Review of Resident #87's quarterly MDS assessment, dated 06/01/24, revealed the resident had intact cognition with a BIMS score of 13. Resident#87 had a feeding tube. Review of Resident #87's care, date 08/02/24, reflected: Focus: The resident required tube feeding rule out Dysphagia (difficulty in swallowing), esophageal varices. Goal: The resident will be free of aspiration through the review date. Interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than (250) ml aspirate. Focus: The resident has a mood problem rule out disease process. Goal: The resident will have improved mood state (Reduction of episodes of yelling out) through the review date. Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #87's September 2024 physician's orders revealed active orders for: depakote sprinkles oral capsule delayed release sprinkle 125 mg (divalproex sodium) give 1 capsule via peg-tube in the morning for mood with a start dated of 09/05/24. Record review of Resident #87's September 2024 physician's orders revealed active orders for: check gastric residual volume every 4 hours and hold feedings if residual was greater than 250 ml return gastric residual volume to stomach and recheck in 4 hours. if enteral feedings are held for gastric residual volume for 3 consecutive checks, notify the physician for additional orders every shift for gastrostomy tube care with a start date of 08/01/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the medication pass on 09/11/24 at 7:51 AM, revealed LVN H failed to check for residual before she administered 2 tablets of Depakote sprinkles oral capsule delayed release sprinkle 125 mg to Resident #87 through his g-tube. Interview on 09/11/24 9:03 AM with LVN H revealed she was supposed to check for the residual before medication administration, but she forgot. She stated the purpose for checking the residual was to monitor if residual was more than 100 ml. LVN H was supposed hold medication administration. She stated having residual more than 100 ml meant Resident #87's food was not being dissolved. She stated failure to check for the residual could lead to resident not receiving the therapeutic dose and could cause aspiration. Interview on 09/11/24 9:07 AM with LVN H revealed she was supposed to check the orders and compare with the medication on hand, before she administered the medication to the resident. She stated Resident #87 was receiving 2 capsules of Depakote 125 mg and the order was changed on 09/05/24. She stated she had been administering as per the blister pack. She stated she did not check the physician orders before administering, and she had no excuse. She stated failure to follow the physician orders could lead to overdose and sedation. She revealed she had received training on medication administration which included administering the correct medication dose and confirming the doctors' orders before medication administration. Interview on 09/12/24 3:37 PM with the DON revealed her expectation was medication should always be administered at the correct dosage. She stated nurses were to follow the seven rights of medication administration. The right person, right medication, right dose, right time, right route, right reason, and right documentation. She also stated the nurse was supposed to verify the dosage since that was the last step for medication administration. She revealed the orders were verified by nursing management once the physician gave new orders for all residents. She revealed the physician orders and what was on hand did not match Resident #87's order. She stated if the facility was not following the physician orders, the resident could have different adverse effects like overdose, underdose and inaccurate treatment. The DON also stated her expectation was that nurses check residual before they administer medication and feeding through gastrostomy tubes. She stated failure to check for residual could lead to Resident#87's medication not being absorbed because residuals meant there was no absorption. The medication would not be received accurately leading to medication not being effective. Review of the facility's current Medication Administration Policy, revised April 2019, reflected the following: 2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. .4. Medications are administered in accordance with prescriber orders, including any required time frame. .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Review of the facility's current Administering Medications through an Enteral Tube Policy, revised November 2018), reflected the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.6. Verify placement of feeding tube: a. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge of Saginaw Health and Wellness	848 W McLeroy Blvd Saginaw, TX 76179

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

42859

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 2 (1 nurses medication cart for 400 hall and medication aide cart for 400 and 200 halls) of 3 carts and 1 refrigerator in the medication room reviewed for pharmacy services.

The facility failed to ensure expired intravenous medications, 3 bottles ampicillin-sulbactam 3 gm/100 ml with expiration dates of 09/03/24, 8 bottles ampicillin-sulbactam 3gm/100mls with expiration dates of 09/07/24, 3 bottles Piperacillin /tazobactam with expiration dates of 09/06/24 and 4 bottles meropenem 1 gm/100mls with expiration dates of 08/18/24, in the Medication Room refrigerator and 11 vials of hydroxyzine with expiration dates of July 2024 in the nurse and 7 sachets of pantoprazole sodium delayed release on the medication aide medication carts with expiration dates of July 2024 were removed and destroyed.

The failure placed residents at risk of receiving medications that were ineffective.

Findings included:

Observation on 09/11/24 2:25 PM of the 200 hall Medication aide cart with MA K revealed 7 sachets of pantoprazole sodium delayed release with an expiration date of 07/24 (July 2024).

Interview on 09/11/24 at 2:30 PM with MA K revealed it was her responsibility to check the cart for expired medications. She stated she checked the cart once a month for expired medications and she could not recall when she last checked her cart. She stated by failing to remove the expired medication, they could be administered and cause reactions, and the resident would not get the required therapy. She stated she had done training on checking carts for expired medications.

Observation on 09/11/24 at 2:39 PM of the 400 Hall nurse medication cart with LVN A revealed 11 vials of hydroxyzine with expiry date of 07/24 (July 2024).

Interview on 09/11/24 at 2:50 PM with LVN A revealed it was all nurses' responsibility to check and remove expired medications from the cart. She stated she checked her cart every shift, but she had not checked when she reported in the morning. She stated she was aware the medications were discontinued a long time and they were supposed to have been removed from the cart and put on the pharmacy destruction box. She stated by failing to remove the expired medication, they could be administered and cause medication error and adverse effect on residents She stated she had done in-services on medication administration and removing of expired medications.

Observation on 09/11/24 at 3:00 PM of the Medication Room refrigerator with LVN B revealed the following:

8 bottles ampicillin-sulbactam 3 gm/100 ml expiry date 09/07/24

(continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3 bottles ampicillin-sulbactam 3 gm/100 ml expiry date 09/03/24 4 bottles meropenem 1 gm/100 ml expiry 08/18/24 3 bottles Piperacillin/tazobactam with expiry date 09/06/24 Interview on 09/11/24 at 3:20 PM with LVN B revealed all nurses were responsible to check the refrigerator but the ADON's were responsible for the refrigerator and medication checks. Interview on 09/11/24 at 3:25 PM with ADON P revealed it was her responsibility and the other ADON J to check the refrigerator, and also nurses were responsible. She stated ADONs are supposed to go behind the nurses to check whether they were removing the expired medications from the refrigerators and carts. She stated she had checked refrigerator two weeks ago. She stated by failing to check for the expired medications, they could be administered and would not be effective. For review ADON B stated she had offered training to staff regarding removing expired medications, but she could not recall when and no training documents were produced for review. Interview on 09/12/24 at 12:09 PM with ADON J revealed it was her responsibility and the other ADON P to check the refrigerator. She stated she had checked refrigerator, on 09/11/24 and all expired intravenous medication were missed. She stated she did not check on the bottles, she only checked on packages that were showing the medications were current. She stated failure to check the carts and the refrigerator for expired dates if administered they will not be effective.The ADON J stated also nurses were responsible of checking for expired medications when they open the refrigerator. She stated ADONs were supposed to go behind the nurses to check whether they were removing the expired medications from the refrigerators and carts. She stated by failing to check for the expired medications, they could be administered and would not be effective. She stated the facility had offered training to staff but she could not recall when. Interview on 09/12/24 at 3:41 PM with the DON revealed the ADONs were responsible to check for expired medication in the refrigerators every two weeks. She stated her ADONs overlooked, and they failed to see the expired medications in the carts and the refrigerator. The DON stated she was responsible for supervision, and she had directed her ADONs to check the carts and refrigerator when the surveyors entered the facility, but it seemed the chain of command failed because her expectation was her ADONs would be the ones to supervise the nurses and medication aides to ensure all expired medications were removed from the carts and the refrigerator. She stated the pharmacist also checked the carts on 08/22/24, and she also missed the expired medications in the cart and the refrigerator. She stated if staff were not checking the refrigerator and medication carts for expired medications and medications were administered to residents, they would not be effective. Review of the facility's Administering Medications policy, revised April 2019, reflected the following: . 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44937 Based on observation, interview, and record review, the facility failed to ensure food, subject to spoilage and removed from its original container, was kept sealed, labeled, and dated in the facility's only kitchen. 1. The facility failed to ensure food items stored in the refrigerator were properly labeled with the contents after being removed from the original packages and dated to reflect when the food items were opened. 2. The facility failed to ensure food items stored in the refrigerator were properly discarded based on expiration date. 3. The facility failed to store ground meat and pot roast were wrapped in plastic wrap away from the original packaging with liquids flowing onto the tray with other items and had turned to a dark/grey color. These failures could place all residents at risk for food contamination and food borne illness. Findings included: Observation of the refrigerator on 09/10/24 beginning at 9:34 AM revealed the following: - observation of bucket of green beans with no label or date; - a tray holding a box of chicken, ground meat, pot roast, and a large brisket that was towards the tray, the tray had dark red liquid that resembled blood that had drained from the brown colored ground meat and pot roast; and - observation of the ground meat and pot roast revealed items had turned to a dark/grey color and they were wrapped in plastic wrap away from its original packaging, not labeled, dated, or sealed properly while being stored. Observation and interview on 09/10/24 at 9:35 AM with the Dietary Manager revealed the tray was stored at the bottom of the fridge for thawing meat to be used in the future. The Dietary Manager stated the brisket was to be used later in the week. The Dietary Manager stated the liquid at the bottom of the tray was from the ground meat and pot roast. However, he did not know how long it had been on the tray because there was no label or date. The Dietary Manager stated the box on the tray had chicken in it. According to the Dietary Manager, his expectations were that the cooks would label and date anything that was taken out of its original packaging. The Dietary Manager stated he and the cooks did a walk through daily to look for items to remove after 7 days of being opened and placed in the refrigerator, and to ensure the refrigerator was wiped down and cleaned. The Dietary Manager stated not properly labeling, dating, or sealing food items could place the food at risk leading to bacterial growth and cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/11/24 at 1:34 PM of the kitchen's steamtable, revealed the far-left compartment had a few inches of water in it as well as food particles which included a green bean, diced carrots, and elbow macaroni noodles. The steamtable compartments to the right already had containers of covered food in them to be served during lunch. Interview on 09/11/24 at 1:35 PM with the [NAME] revealed the steam table was cleaned twice per week. The [NAME] stated she was responsible for adding water to the table to keep food warm during serving times. The [NAME] stated she was responsible for cleaning out the steam table, however she was not sure how long the food particles had been in the steam table. The [NAME] stated not cleaning out the steam table of food particles placed residents at risk of food contamination and illness. Observation and interview on 09/11/24 at 1:37 PM with the Dietary Manager revealed the steam table was cleaned twice a week by the cooking staff. The Dietary Manager stated the cook was to drain the water after each cleaning and serving, and ensure there was no water or food left that may have fell . Observation of the steam table in the kitchen during lunch with The Dietary Manager revealed the steam table with food particles (several carrots, macaroni, green beans) in the water. The Dietary Manager stated the team was working on getting the steam table cleaned to prevent particles in the food and cross contamination. Interview on 09/12/24 at 4:40 PM with the Administrator revealed the Dietary Manager was responsible for overseeing the kitchen area and ensuring food was properly labeled, dated, sealed, stored and served in a way to prevent food contamination and food borne illness. Administrator stated he expected all staff in the kitchen to follow guidelines which would not place residents at risk of illnesses. Review of the facility's policy dated 06/01/19, titled Food Storage, reflected: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Use all leftovers within 72 hours. Discard items that are over 72 hours old. Store raw meats and eggs on the bottom shelf to prevent contamination of other foods. Review of the facility's policy dated 10/01/18 titled Sanitizing Equipment In-Place, reflected: The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for cleaning equipment in place in order to ensure that all equipment is thoroughly cleaned and sanitized to minimize the risk of food hazards. Unplug electrically powered equipment . Remove any fallen food particles and scraps. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wash, rinse and sanitize removable parts using the manual immersion method described in Policy 04.005. Wash the remaining food-contact surfaces, and rinse with clean water. Wipe down with a chemical sanitizing solution mixed according to the manufacturer's directions. Protect all food-contact surfaces of fixed equipment from contamination. Protect all food-contact surfaces of fixed equipment from contamination.