STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675638	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN PINES NURSING AND REHABILITATION	3301 E. MOCKINGBIRD LANE VICTORIA, TX 77904

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

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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive assessment was completed within 14 calendar days after admission for 1 of 7 residents (Resident #214) reviewed for assessments, in that: The facility did not complete a comprehensive assessment for Resident #214 within 14 calendar days after the resident's admission to the facility. This deficient practice could place residents newly admitted to the facility at risk for not receiving appropriate care and services. The findings were: Record review of Resident #214's face sheet, dated 03/05/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #214's Admission MDS, start date 0[DATE], revealed the resident's assessment had not been completed. During an interview with RN Q on 03/06/2020 at 9:59 a.m., RN Q confirmed Resident #214's Admission MDS was not completed within 14 days of the resident's admission to the facility on [DATE]. Record review of the facility's policy titled Resident Assessment, dated 11/01/2017, revealed, The facility shall conduct a comprehensive, accurate, standardized, and reproducible assessment on admission and periodically of each resident's functional capacity. The facility shall use a State-approved Resident Assessment Instrument (RAI) in accordance with timeframes. Specified timefames: Annual - Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to encode or transmit a resident assessment to C[CONDITION] within the required time frame for 1 of 3 discharged residents (Resident #1) reviewed for data encoding and transmission, in that: Resident #1's Discharge MDS was not encoded or transmitted to C[CONDITION] as of 03/06/2020 at 9:59 a.m. This deficient practice could place residents who have been discharged from the facility at risk of not having their assessments transmitted in a timely manner. The findings were: Record review of Resident #1's face sheet, dated 03/06/2020, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's clinical record revealed the resident's Admission MDS was completed and accepted, but the Discharge MDS assessment was not initiated to where the assessment would be visible, encoded, or transmitted to C[CONDITION] as of 03/06/2020 at 9:59 a.m. Record review of Resident #1's Discharge Summary, dated 12/14/2019, revealed the resident was discharged to home via wheelchair on 12/14/2019. During an interview with ADON R on 03/06/2020 at 11:55 a.m., ADON R confirmed a Discharge MDS for Resident #1 had not been encoded or transmitted. During an interview with Corporate Nurse T on 03/06/2020 at 3:54 p.m., Corporate Nurse T confirmed the facility had no policy regarding the timely creation of MDS assessments upon residents' discharge. Record review of the RAI (Resident Assessment Instrument) Manual OBRA Assessment Summary, dated 10/2017, revealed, OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated. Further review revealed the Discharge MDS (Minimum Data Set) must be completed within 14 days after the discharge date and must be submitted within 14 days after the MDS completion date.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out ADLs received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 13 residents (Resident #414) reviewed for ADLs, in that: The facility did not trim and clean Resident #414's fingernails. This deficient practice could place residents who were dependent on assistance with ADLs at risk of harboring and transmitting germs. The findings were: Record review of Resident #414 face sheet, dated 03/06/2020 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #414's Admission MDS, dated [DATE], revealed the resident was admitted on [DATE] and there was no BIMs score documented. Observation on 03/03/2020 at 12:10 p.m. revealed Resident #414 lying in his bed. Further observation revealed the resident's nails were long, approximately three cm long, with some darkened areas underneath some of his nails. Further observation revealed Resident #414 was unable to move his left hand. During an interview with Resident #414 on 03/03/2020 at 12:10 p.m., the resident stated it would be nice to have his fingernails cut. Observation on 03/05/2020 at 7:31 a.m. revealed Resident #414 was self propelling himself in his wheelchair with his right hand in the hallway. Further observation revealed the resident's left hand was resting on his lap, and his fingernails on both hands had long nails with darkened material under it. During an interview with the Consultant LVN on 03/05/2020 at 7:31 a.m., at the same time as the observation, the Consultant LVN stated he would get one of the facility's nurse to cut Resident #414 fingernails if he, is diabetic, and if not then a CNA. During an interview with CNA N on 03/05/2020 at 10:55 a.m., CNA N stated she provided ADL care for Resident #414, and further stated bathing and hygiene was completed every other day in the hallway where Resident #414's room was located. During an interview with Administrator on 03/06/2020 at 3:46 p.m., the Administrator confirmed the facility did not have a policy regarding maintaining grooming, and personal and oral hygiene.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 34 residents (Resident #147) reviewed for care, in that: Resident #147 did not receive restorative care for the resident's both upper extremities to maintain current level of strength as the restorative nursing care plan. This deficient practice could place residents with limited range of motion at risk for decline in range of motion and decreased

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

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.

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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** Based on observation, interview, and record review, the facility failed to ensure each resident environment remained as free of accident hazards as possible for 1 of 33 residents (Resident #109) whose environment was reviewed for accidents and hazards, in that: A wooden board was placed next to Resident #109's fall mat in the resident's room. This deficient practice could place residents at risk of injury due to avoidable accidents. The findings were: Record review of Resident #109's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #109's care plan, revised 04/19/2019, revealed a focus which read, Resident with decreased vision related to dx (diagnosis) of [MEDICAL CONDITION] and needs to be monitored for complications, an associated goal which read, Resident will be free from injury and will function in safe, secure environment x 90 days, and an associated intervention which read, Keep environment free of small objects, clutter, and floors clean, dry. Further review revealed a focus which read, Resident is at risk for falls D/T (due to) increased weakness and decreased mobility skills, with associated interventions which read, bed lowest position while in bed with floor mat in place while in bed, and, floor clean and dry, and clutter free environment. Record review of Resident #109's Significant Change MDS, dated [DATE], revealed the resident's BIMS score was 2, which indicated the resident was severely cognitively impaired, and required extensive assistance from one or more people to perform activities of daily living such as: bed mobility, transferring, dressing, eating, toilet use, and maintaining personal hygiene. Further review revealed the resident was, not steady, only able to stabilize with staff assistance, when moving from seated to standing position and when transferring from surface to surface. Observation in Resident #109's room on 03/03/2020 at 4:40 p.m. revealed there was a wooden board, approximately two inches wide, eight inches tall, and six feet long, lying lengthwise on the floor on its two-inch side, between the wall and the resident's floor mat, and touching both the wall and the floor mat. During an interview with LVN Z on 03/03/2020 at 4:40 p.m., at the same time as the observation, LVN Z confirmed there was a wooden board, approximately two inches wide, eight inches tall, and six feet long, lying lengthwise on the floor on its two-inch side, between the wall and the resident's floor mat, and touching both the wall and the floor mat. LVN Z confirmed the floor mats had been placed because Resident #109 was at risk of falling from his bed, and confirmed the board was a tripping hazard for the resident when ambulating or by rolling into the board from the floor mat. During an interview with Maintenance Assistant Y on 03/03/2020 at 4:50 p.m., Maintenance Assistant Y confirmed there was wooden board, approximately two inches wide, eight inches tall, and six feet long, lying lengthwise on the floor on its two-inch side, between the wall and the resident's floor mat, and touching both the wall and the floor mat in Resident #109's room. Maintenance Assistant Y stated the board had been purposely placed between the wall and the resident's floor mat in an attempt to prevent the resident's bed from being placed near the window, and to prevent the rising and lowering motion of the resident's bed from dislodging the window ledge, saying the ledge had become dislodged previously. During an interview with Corporate LVN T on 03/06/2020 at 3:54 p.m., Corporate LVN T confirmed the facility had no policy regarding physical environment: safety/accident hazards and facility repair.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 4 of 5 residents (Residents #416, #215, #364, and #115) reviewed for [MED]gen and breathing treatment, in that: 1. Resident #416's [MED]gen tubing and nasal cannula were not dated. 2. Resident #215's [MED]gen tubing, nasal cannula, and humidifier were not dated. 3. Resident #364's [MED]gen concentrator's air filter was covered with white dust. 4. Resident #115's nebulizer tubing was dated on 02/23/2020, nebulizer mask was not dated, and the nebulizer mask was not covered in a plastic bag when not in use. These deficient practices could place residents who receive [MED]gen therapy and breathing treatments at risk for receiving incorrect or inadequate [MED]gen and breathing treatment and could result in a decline in health. The findings were: 1. Record review of Resident #416's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #416's physician's orders [REDACTED]. Observation on 03/05/2020 at 10:55 a.m. in the B Wing Hallway revealed Resident #416 was receiving [MED]gen at 2 liters per minute via the nasal cannula. Further observation revealed the resident's [MED]gen tubing and nasal cannula were not dated. During an interview with RN O on 03/05/2020 at 10:55 a.m., at the same time as the observation, RN O confirmed Resident #416's [MED]gen tubing and nasal cannula were not dated and the tubing, should have been changed. RN O stated the person who was responsible to change the the resident's tubing, must have forgotten, to change it. 2. Record review of Resident #215's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #215's physician's orders [REDACTED]. Observation on [DATE]20 at 1:41 p.m. revealed Resident #215 received [MED]gen via a nasal cannula connected to an [MED]gen concentrator. Further observation revealed the resident's [MED]gen tubing, nasal cannula, and humidifier were not dated. During an interview with LVN A on [DATE]20 at 1:46 p.m., LVN A confirmed Resident #215 was receiving [MED]gen therapy, and the resident's [MED]gen tubing, nasal cannula, and humidifier were not dated. 3. Record review of Resident #364's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #364's physician's orders [REDACTED]. Observation on 03/04/2020 at 11:15 a.m. revealed Resident #364 received [MED]gen via a nasal cannula, and the [MED]gen concentrator's air filter was covered by white particles. During an interview with LVN E on 03/04/2020 at 11:16 a.m., LVN E confirmed Resident #364's [MED]gen concentrator's air filter was covered by white particles, and the white particles were dust. 4. Record review of Resident #115's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE], and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #115's physician's orders [REDACTED].#115's nebulizer was on the resident's night stand with mask and tubing. Further observation revealed the tubing was dated 02/23/2020, the nebulizer mask was not dated, and the nebulizer mask was not covered in a plastic bag. During an interview with LVN A on [DATE]20 at 1:19 p.m., LVN A confirmed Resident #115's nebulizer tubing was dated

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 4 CNAs (CNA H) were able to demonstrate competency in the provision of skills and techniques necessary to care for 1 of 4 residents (Resident #46) reviewed for nursing care, in that: While providing perineal care to Resident #46, CNA H did not sanitize or wash her hands between changing gloves. This deficient practice could place residents who receive perineal care at-risk for infection due to improper care practices. The findings were: Record review of Resident #46's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE], and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Observation on 03/05/2020 at 10:50 a.m. revealed during perineal care for Resident #46, CNA H knocked on the door, explained the procedure to the resident, provided privacy, washed her hands with water, and donned new gloves. CNA H removed the floor mat to the bed side to get space for the care. CNA H removed the gloves after touching the floor mat and then donned new gloves without washing or sanitizing her hands. CNA H opened old brief and cleaned the resident's perineal area. During an interview with CNA H on 03/05/2020 at 11:00 a.m., CNA H confirmed she did not wash or sanitize her hand after removing the gloves after touching the floor mat and donned new gloves. During an interview with the Administrator on 03/06/2020 at 3:46 p.m., the Administrator confirmed the facility did not have policies and procedures regarding hand washing between changing gloves. During an interview with the DON on 03/05/2020 at 5:30 p.m., the DON confirmed CNA H should have washed or sanitized her hands between each glove changes.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to include administering to meet the needs of each resident for 1 of 3 residents (Resident #37) and for 1 of 2 medication rooms ([LOC] Medication Room) reviewed for medications, in that: 1. During medication pass, LVN O crushed Resident #37's [MEDICATION NAME] 25 mg ER tablet and was going to administer this medication in this form to the resident via [DEVICE] until this surveyor intervened. 2. In the [LOC] Medication Room there were six expired sets of IV kits and seven expired sets of IV start kits. These deficient practices could places residents who receive medications at risk for not receiving the therapeutic effects of medications and adverse reaction to utilizing expired equipment. The findings were: 1. Record review of Resident #37's face sheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] (Initial admitted : [DATE]) with [DIAGNOSES REDACTED]. Record Review of Resident #37's Quarterly MDS, dated [DATE], revealed a staff assessment indicated Resident #37 had short term and long term memory problems. Further review reavealed Resident #37 had moderately impaired cognitive skills for daily decision making. Record review of Resident #37's physician's orders [REDACTED]. Further review revealed the order did not indicate the medication should be crushed. Further review revealed the resident's orders had last been reviewed on [DATE]. Record review of Resident #37's MAR for [DATE] revealed resident received [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG- Give 1 tablet via [DEVICE] two times a day related to Essential (Primary) Hypertension, twice daily from [DATE] to [DATE]. Further review revealed the order did not indicate the medication should be crushed. Record review of Resident #37's MAR for February 2020 revealed resident received, [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG- Give 1 tablet via [DEVICE] two times a day related to Essential (Primary) Hypertension, twice daily from [DATE] to [DATE], and twice daily except for [DATE], [DATE], and [DATE] where only evening doses were checked as administered. Further review revealed the order did not indicate the medication should be crushed. Record review of Resident #37's MAR for [DATE] revealed resident received, [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG- Give 1 tablet via [DEVICE] two times a day related to Essential (Primary) Hypertension, twice daily from [DATE] to [DATE], and twice daily except for [DATE], where only evening dose was checked as administered. Further review revealed the order did not indicate the medication should be crushed. Observation on [DATE] at 7:26 a.m. revealed LVN O crushed one [MEDICATION NAME] 25 mg ER tablet and was going to administer the medication in this form to Resident #37 via the resident's [DEVICE] until this surveyor intervened. During an interview with LVN O on [DATE] at 7:53 a.m., LVN O confirmed she had crushed Resident #37's [MEDICATION NAME] 25 mg ER prior to administering the medication to the resident via the resident's [DEVICE]. LVN O confirmed Resident #37's physician should be contacted regarding the order to crush [MEDICATION NAME] ER before administering this medication to Resident #37. LVN O stated Resident #37 routinely receives crushed [MEDICATION NAME] 25 mg ER through his [DEVICE]. During an interview with ADON R on [DATE] at 7:52 a.m., ADON R confirmed Resident #37's order for [MEDICATION NAME] 25 mg ER did not indicate the medication could be crushed. ADON R stated she would call the resident's physician for clarification regarding crushing the medication. 2. Observation on [DATE] at 2:21 p.m. revealed there were six expired sets of IV kits and seven expired sets of IV start kits in the [LOC] Medication Room. During an interview with LVN S on [DATE] at 2:21 p.m., LVN S confirmed there were six expired sets of IV kits and seven expired sets of IV start kits in the [LOC] Medication Room. Record review of the facility's policy titled Pharmacy Services- Pharmacy Services/Procedures/Pharmacist/Records, dated [DATE], revealed: Policy: The facility must 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. Record review of Drugs and Supplements: [MEDICATION NAME] (Oral Route) https://www.mayoclinic.org/drugs-supplements/[MEDICATION NAME]-oral-route/proper-use/drg- 141, revised [DATE], revealed: Swallow the extended-release capsule and tablet whole. Do not crush, break, or chew them. If you cannot swallow the extended-release capsule: You may open it and sprinkle the contents over a small amount (teaspoonful) of soft food (including applesauce, pudding, or yogurt). Swallow the mixture within 60 minutes. Do not store for later use. You may also use a nasogastric tube to give the medicine. Mix the contents of the opened capsule with water into a syringe. Gently shake the mixture for about 10 seconds, then flush it through the tube. Rinse the tube with water until all of the medicine is washed out. Take the tablet or extended-release tablet with a meal or just after you eat. You may break the extended-release tablet into two pieces, but swallow the two pieces whole and do not crush or chew them.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent for 2 errors out of 27 opportunities which resulted in a 7.41 percent error rate, in that: 1. MA M administered [MED] one tablet 325 mg by mouth to Resident #133 but the resident's physician order [REDACTED]. 2. LVN O crushed one [MEDICATION NAME] 25 mg ER tablet and was going to administer this medication in this form to Resident #37 via [DEVICE] until this surveyor intervened. These deficient practices could place residents who receive mediations at-risk for not receiving the intended therapeutic benefit of their medications. The findings were: 1. Record review of Resident #133's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE], and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #133's physician order, dated 03/06/2020, revealed an order for [REDACTED].#133. During an interview with MA M on 03/05/2020 at 10:17 a.m., MA M confirmed she had administered [MED] one tablet 325 mg by mouth to Resident #133 at 9:12 a.m. on 03/05/2020, but the physician order [REDACTED].#133. MA M further confirmed she should have administered [MED] 500 mg to the resident, and further confirmed this was a medication error. During an interview with the DON on 03/05/2020 at 5:30 p.m., the DON confirmed MA M should have administered [MED] 500 mg one tablet by mouth to Resident #133 per the resident's physician order. 2. Record review of Resident #37's face sheet, dated 03/05/2020, revealed the resident was admitted to the facility on [DATE] (Initial admitted : 0[DATE]6/2019) with [DIAGNOSES REDACTED]. Record Review of Resident #37's Quarterly MDS, dated [DATE], revealed a staff assessment indicated Resident #37 had short term and long term memory problems. Further review reavealed Resident #37 had moderately

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) impaired cognitive skills for daily decision making. Record review of Resident #37's physician's orders [REDACTED]. Further review revealed the order did not indicate the medication should be crushed. Further review revealed the resident's orders had last been reviewed on 02/07/2020. Record review of Resident #37's MAR for March 2020 revealed resident received [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG- Give 1 tablet via [DEVICE] two times a day related to Essential (Primary) Hypertension, twice daily from 03/01/2020 to 03/04/2020. Further review revealed the order did not indicate the medication should be crushed. Record review of Resident #37's MAR for February 2020 revealed resident received, [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG- Give 1 tablet via [DEVICE] two times a day related to Essential (Primary) Hypertension, twice daily from 02/01/2020 to 02/29/2020, and twice daily except for 0[DATE], 02/21/2020, and 02/25/2020 where only evening doses were checked as administered. Further review revealed the order did not indicate the medication should be crushed. Record review of Resident #37's MAR for January 2020 revealed resident received, [MEDICATION NAME] ER Tablet Extended Release 24 Hour 25 MG- Give 1 tablet via [DEVICE] two times a day related to Essential (Primary) Hypertension, twice daily from 01/01/2020 to [DATE], and twice daily except for 01/02/2020, where only evening dose was checked as administered. Further review revealed the order did not indicate the medication should be crushed. Observation on 03/05/2020 at 7:26 a.m. revealed LVN O crushed one [MEDICATION NAME] 25 mg ER tablet and was going to administer the medication in this form to Resident #37 via the resident's [DEVICE] until this surveyor intervened. During an interview with LVN O on 03/05/2020 at 7:53 a.m., LVN O confirmed she had crushed Resident #37's [MEDICATION NAME] 25 mg ER prior to administering the medication to the resident via the resident's [DEVICE]. LVN O confirmed Resident #37's physician should be contacted regarding the order to crush [MEDICATION NAME] ER before administering this medication to Resident #37. LVN O stated Resident #37 routinely receives crushed [MEDICATION NAME] 25 mg ER through his [DEVICE]. Record review of the facility's policy titled Oral (PO) Administration of Medication, dated 01/01/2010, revealed, 1. To administer oral medications in an organized and safe manner. Record review of Drugs and Supplements: [MEDICATION NAME] (Oral Route) https://www.mayoclinic.org/drugs-supplements/[MEDICATION NAME]-oral-route/proper-use/drg- 141, revised 02/01/2020, revealed: Swallow the extended-release capsule and tablet whole. Do not crush, break, or chew them. If you cannot swallow the extended-release capsule: You may open it and sprinkle the contents over a small amount (teaspoonful) of soft food (including applesauce, pudding, or yogurt). Swallow the mixture within 60 minutes. Do not store for later use. You may also use a nasogastric tube to give the medicine. Mix the contents of the opened capsule with water into a syringe. Gently shake the mixture for about 10 seconds, then flush it through the tube. Rinse the tube with water until all of the medicine is washed out. Take the tablet or extended-release tablet with a meal or just after you eat. You may break the extended-release tablet into two pieces, but swallow the two pieces whole and do not crush or chew them.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to assure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 15 carts ([LOC] Nursing Cart and [LOC] Medication Aide Cart) and 1 of 2 medication rooms ([LOC] Medication Room) reviewed for medication storage, in that: 1. On the [LOC] Nursing Cart, Resident #162's [MED] was opened on [DATE] but was still in use on [DATE] instead of being disposed of after 28 days ([DATE]). 2. On the [LOC] Medication Aide Cart there was one medication not specified for a specific resident with an expiration date of ,[DATE]. 3. In the [LOC] Medication Room there were three expired syringes of [MEDICATION NAME] (anticoagulant medication) IV Flush and one expired syringe of [MEDICATION NAME] Lock Flush Solution. These deficient practices could place residents who receive medications at-risk for not receiving the intended therapeutic benefit of their medications. The findings were: 1. Record review of Resident #162's face sheet, dated [DATE], revealed the resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #162's physician orders, dated [DATE], revealed an order for [REDACTED]. Observation on [DATE] at 2:17 p.m. revealed Resident #162's bottle of [MEDICATION NAME] injection 100 ml solution was stored in the [LOC] Nursing Cart. Further observation revealed the bottle was labeled with an open date of [DATE]. During an interview with RN F on [DATE] at 2:44 p.m., RN F confirmed Resident #162's [MED] [MEDICATION NAME] was opened on [DATE] and was still in use. RN F further confirmed Resident #162's [MED] [MEDICATION NAME] should have been discarded on [DATE] because it was passed 28 days after its initial use. 2. Observation on [DATE] at 2:53 p.m. revealed there was a bottle of [MEDICATION NAME] Syrup [MEDICATION NAME] Sodium 60 mg/ 15 mL Stool Softener 16 FL OZ (473 mL) with expiration date ,[DATE] on the [LOC] Medication Aide Cart. During an interview with LVN K on [DATE] at 2:53 p.m., LVN K confirmed there was a bottle of [MEDICATION NAME] Syrup [MEDICATION NAME] Sodium 60 mg/ 15 mL Stool Softener 16 FL OZ (473 mL) with expiration date ,[DATE] on the [LOC] Medication Aide Cart. 3. Observation on [DATE] at 2:21 p.m. revealed there were three expired syringes of [MEDICATION NAME] IV Flush and one expired syringe of [MEDICATION NAME] Lock Flush Solution in the [LOC] Medication Room. During an interview with LVN S on [DATE] at 2:21 p.m., LVN S confirmed there were three expired syringes of [MEDICATION NAME] IV Flush and one expired syringe of [MEDICATION NAME] Lock Flush Solution in the [LOC] Medication Room. Record review of [MEDICATION NAME] - How to Inject [MEDICATION NAME] with a Vial and Syringe (https://www.[MEDICATION NAME].com/using-[MEDICATION NAME]-[MED]-pen#vial_syringe), dated 2019, revealed, Storage Instructions: . The [MEDICATION NAME] vials you are using should be thrown away after 28 days, even if it still has [MED] left in it. Record review of the facility's policy and procedure titled How to Supplied/Storage and Handling, undated, revealed, 16.2 - For [MEDICATION NAME] in-use (opened): discard after 28 days at refrigerated or room temperature. Record review of the facility's policy titled Pharmacy Services-Label/Storage of Drugs and Biologicals, dated [DATE], revealed, Objective: To provide the appropriate pharmacy services and safe & effective medication use for each resident admitted to the facility.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident recives and the facility provides food that accommodate resident allergies [REDACTED].#215) reviewed for food preferences, in that: Resident #215's meal card did not list the resident's food allergies [REDACTED]. The findings were: Record review of Resident #215's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #215's Admission MDS, dated [DATE], revealed the resident had a BI[CONDITION] score of 15, which indicated the resident was cognitively intact. Record review of Resident #215's physician's orders [REDACTED].#215's care plan, dated 03/02/2020, revealed the resident's allergies [REDACTED]. Record review of Resident #215's meal card revealed, Regular, NO FRIED FOODS. NO PEANUT BUTTER. Further review revealed the resident's did not list the resident's allergies [REDACTED].#215 on 03/04/2020 at 10:44 a.m., Resident #215 stated she was, allergic to pork and was served pork last night. During an interview with Dietary Supervisor P on 03/04/2020 at 11:31 a.m., Dietary Supervisor P confirmed Resident #215's meal card did not list the resident's allergies [REDACTED]. Policy: Menus must: Meet the nutritional needs of residents in accordance with established national guidelines and be reviewed by the facility's dietician or other clinically qualified nutrition professional for nutritional adequacy.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to include handwashing and to help prevent the development and transmission of communicable diseases for 2 of 34 residents (Residents #46 and #99) whose care was reviewed, in that: 1. While providing perineal care for Resident #46, CNA H did not sanitize or wash her hands between changing gloves. 2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675638	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN PINES NURSING AND REHABILITATION	3301 E. MOCKINGBIRD LANE VICTORIA, TX 77904

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Resident #99's indwelling urinary catheter tubing was touching the floor. These deficient practices could place residents who receive perineal care and residents with catheters at-risk for infection and skin break down due to improper care practices. The findings were: 1. Record review of Resident #46's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE], and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Observation on 03/05/2020 at 10:50 a.m. revealed during perineal care for Resident #46, CNA H removed the floor mat to the bed side to get space for the care. Further observation revealed CNA H removed the gloves after touching the floor mat and then donned new gloves without washing or sanitizing her hands. CNA H then opened old brief and cleaned the resident's perineal area. During an interview with CNA H on 03/05/2020 at 11:00 a.m., CNA H confirmed she did not wash or sanitize her hand after removing the gloves after touching the floor mat and donned new gloves. 2. Record review of Resident #99's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #99's Quarterly MDS, dated [DATE], revealed the resident had an indwelling urinary catheter. Record review of Resident #99's physician orders, dated 03/06/2020, revealed the resident had an order for [REDACTED].#99 was sitting on wheelchair and pushing her wheelchair in the dining room to go somewhere. Further observation revealed the indwelling urinary catheter tubing was touching the floor. During an interview with LVN J on 03/05/2020 at 3:11 p.m., LVN J confirmed Resident #99's indwelling urinary catheter tubing was touching the floor. During an interview with the DON on 03/05/2020 at 5:30 p.m., the DON confirmed CNA H should have washed or sanitized her hands between each glove changes. The DON further confirmed Resident #99's indwelling urinary catheter tubing should not have been touching on the floor. During an interview with the Administrator on 03/06/2020 at 3:46 p.m., the Administrator confirmed the facility did not have policies and procedures regarding hand washing between changing gloves and indwelling urinary catheter care.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide a safe and sanitary environment for 1 of 2 dining rooms (Main Dining Room), 1 of 34 residents' beds (Resident #115), and 1 of 34 residents' rooms (Resident #109) reviewed for environment, in that: 1. Resident #115's bed controller was dirty with black oily particles. 2. The window ledge in Resident #109's rooms was damaged with jagged, splintered wood trim. 3. In the Main Dining Room, there was a large air conditioning vent that was dirty with dust. These deficient practices could place residents who ate meals in the Main Dining Room, residents who used bed controllers, and residents who had windows in their rooms at-risk for exposure to unsafe and unsanitary living conditions. The findings were: 1. Record review of Resident #115's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE], and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Observation on [DATE]20 at 1:06 p.m. revealed Resident #115's bed controller was very dirty with black oily particles. During an interview with LVN A on [DATE]20 at 1:19 p.m., LVN A confirmed Resident #115's bed controller was very dirty with black oily particles, and the resident could use her bed controller without any problem. 2. Record review of Resident #109's face sheet, dated 03/06/2020, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #109's care plan, revised 0[DATE]9/2019, revealed a focus which read, Resident with decreased vision related to dx (diagnosis) of [MEDICAL CONDITION] and needs to be monitored for complications, an associated goal which read, Resident will be free from injury and will function in safe, secure environment x 90 days, and an associated intervention which read, Keep environment free of small objects, clutter, and floors clean, dry. Further review revealed a focus which read, Resident is at risk for falls D/T (due to) increased weakness and decreased mobility skills, with associated interventions which read, bed lowest position while in bed with floor mat in place while in bed, and, floor clean and dry, and clutter free environment. Record review of Resident #109's Significant Change MDS, dated [DATE], revealed the resident's BI[CONDITION] score was 2, which indicated severely cognitively impaired. Observation on [DATE]20 at 4:40 p.m. revealed one side of the window ledge in Resident #109's room was raised approximately two inches out of position with damaged gypsum and splintered wood present. During an interview with Resident #109 on [DATE]20 at 4:40 p.m., at the same time of the observation, the resident stated, The whole thing is coming loose, you can stick your hand in there, and confirmed he disliked having his window ledge in a state of disrepair. During an interview with LVN Z on [DATE]20 at 4:40 p.m., LVN Z confirmed one side of the window ledge in Resident #109's room was raised approximately two inches out of position with damaged gypsum and splintered wood present. During an interview with Maintenance Assistant Y on [DATE]20 at 4:50 p.m., Maintenance Assistant Y confirmed one side of the window ledge in Resident #109's room was raised approximately two inches out of position with damaged gypsum and splintered wood present. Maintenance Assistant Y stated the ledge had become damaged previously when the raising and lowering of the resident's bed dislodged the ledge. 3. Observation on [DATE]20 at 12:37 p.m. in the Main Dining Room revealed there was a large air conditioner vent located above the second kitchen door, and the vent was covered in a dark black-colored powdery substance. During an interview with LVN K on [DATE]20 at 12:40 p.m., LVN K confirmed the large air conditioning vent in the Main Dining Room above the second kitchen door was covered in a dark black-colored powdery substance that she had identified as dust. During an interview with Housekeeper Supervisor L on [DATE]20 at 12:47 p.m., Housekeeper Supervisor L confirmed the large air conditioning vent in the Main Dining Room above the second kitchen door was covered in a dark black-colored powdery substance she had identified as dust. Housekeeper Supervisor L confirmed the vent should be cleaned once a week. During an interview with the Administrator on 03/06/2020 at 3:46 p.m., the Administrator confirmed the facility did not have policies and procedures for cleaning air vents and resident's bed controller.