STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676137	A. BUILDING _____ B. WING _____	09/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION CENTER -	8902 WEST RD HOUSTON, TX 77064

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights for one resident (Resident #72) of one reviewed for care plans. -The facility failed to follow physician orders [REDACTED].#72. This failure could affect residents in the facility with [DEVICE]s, placing them at risk for metabolic abnormalities, medical complications, or a decline in health due to not following appropriate procedures. Findings include: Resident #72 Record review of Resident #72's admission record revealed she was [AGE] years old and was re-admitted to the facility on [DATE]. She was originally admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. History of gastrostomy malfunction, dysphagia, pneumonia, acute [MEDICAL CONDITION] with [MEDICAL CONDITIONS], hypertensive heart and [MEDICAL CONDITION]. Record review of Resident #72's care plan date initiated 10/15/2019 revealed: -Focus: Resident #72 has potential nutritional problem: less than body requirements related to (r/t) [MEDICAL CONDITION], new feeding tube status. -Goal: Will maintain adequate nutritional status as evidenced by maintaining weight with no s/sx of malnutrition through review date. -Interventions included: administer tube feeding and flushes as prescribed. -Focus: Resident #72 has tube feeding r/t dysphagia -Goal: will remain free of side effects or complications related to tube feeding through review date. -Interventions included: is dependent with tube feeding and water flushes. See MD orders for current feeding orders. -Focus: Resident #72 has potential fluid deficit r/t tube feedings. -Goal: Will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. -Interventions included: administer tube feeding and flushes as prescribed. Record review of Resident #72's quarterly Minimum Data set ((MDS) dated [DATE] revealed her Brief Interview for Mental status (BIMS) was scored 15 out of 15 indicating her cognition was intact. The resident required extensive assistance of one staff for her bed mobility, transfers and toilet use. She was occasionally incontinent of bladder and bowel. Record review of Resident #72's active physician order [REDACTED]. -Enteral feed order every shift may crush/combine medication for administration if not contraindicated and mix with 4 oz of water. May use slow push to facilitate consumption, start date 11/21/2019. Record review of Resident #72's September 2020 MAR indicated [REDACTED]. Observation and interview on 09/09/2020 at 8:00 AM, RN 1 crushed oral tablets and placed each into 9 different medication cups, added 10 ml water to each medication cup and mixed. After checking placement and flushing with 30 ml water she poured each medication cup into [DEVICE] and added 20-30 ml of water after each medication cup. The total water was 180 to 270 ml water while administering 9 medication cups. When asked how did she knew how much water to use between each medication, she said she used 15-30 ml water because that was what the physician ordered. In an interview with DON on 09/11/2020 at 10:30 AM, when asked to describe the policy and procedure for [DEVICE] flushes, she said 10 ml of water between medications and nurses should be following MD orders as written. Record review of facility policy/procedure titled Gastrostomy Tube revised 08/2018, read in part: Policy: it is the policy of this facility to provide proper care and maintenance of gastrostomy tube. Procedures: Administering Medications through Feeding Tubes .Flush the tube again with 5-10 cc of water after administering each medication
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 residents who needed respiratory care were provided such care, consistent with professional standards of practice, for oxygen therapy for 4 of 5 residents (Residents #72, #76, and #21) reviewed for respiratory care. -The facility failed to administer Resident #72, #76, and #21 oxygen as ordered by the physician. -The facility failed to change oxygen tubing as ordered by physician for Resident #76. These failures could affect residents receiving oxygen therapy, placing them at risk of adverse impact on their health. Findings include: Resident #72 Record review of Resident #72's admission record revealed she was [AGE] years old who was re-admitted to the facility on [DATE]. She was originally admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. History to include gastrostomy malfunction, gastro-[MEDICAL CONDITION] reflux disease (GERD),dysphagia, pneumonia, acute [MEDICAL CONDITION] with [MEDICAL CONDITIONS], hypertensive heart and [MEDICAL CONDITION]. Record review of Resident #72's care plan revealed focus areas with date initiated 04/25/2018 and revised on 10/28/2019: -Focus: Resident is at risk of impaired gas exchange related to (r/t) [DIAGNOSES REDACTED]. Goal: Will display optimal breathing pattern daily through review date. -Interventions included: give aerosol or [MEDICATION NAME][MEDICATION NAME] as ordered . Give oxygen therapy as ordered by the physician. -Focus: Resident has oxygen therapy r/t [MEDICAL CONDITION]. -Goal: Will have no signs or symptoms of poor oxygen absorption through the review date. -Interventions included: Oxygen settings: oxygen at 3 liters per minute continuous per nasal cannula (NC). Record review of Resident #72's significant change Minimum Data set ((MDS) dated [DATE] revealed her Brief Interview for Mental status (BIMS) was scored 15 out of 15 to indicate her cognition was intact. She required extensive assistance of one staff for her bed mobility, transfers and toilet use. She was occasionally incontinent of bladder and bowel. She required oxygen therapy for respiratory treatments while a resident. Record review of Resident #72's active physician order summary report as of 09/10/2020 revealed an order for [REDACTED].#72 receiving oxygen via nasal cannula. The oxygen concentrator was set at 4 liters per minute. Observation on 09/09/2020 at 5:45 AM revealed Resident #72 receiving oxygen via nasal cannula. The oxygen concentrator was set at 4 liters per minute. Resident #76 Record review of Resident #76's admission record revealed he was [AGE] years old and was re-admitted to the facility on [DATE]. He was originally admitted on [DATE]. His [DIAGNOSES REDACTED].#76's care plan date initiated 09/08/2020 and revised on 09/09/2020 revealed: -Focus: Resident has oxygen therapy related to ineffective gas exchange. -Goal: Will have no signs and symptoms of poor oxygen absorption through the review date. -Interventions included: oxygen via nasal cannula at 2 liters per minute continuously. Record review of Resident #76's admission MDS dated [DATE] revealed his BIMS was scored 12 out of 15 to indicate he had moderately impaired cognitive skills. The resident required extensive assistance of one staff for his bed mobility, dressing, toilet use and personal hygiene. He was frequently incontinent of bladder and bowel. There were no areas marked as checked under Respiratory Treatments. Record review of Resident #76's active physician order summary report as of 09/10/2020 revealed an order to change oxygen tubing and humidifier bottle every night shift every Wednesday and an order for [REDACTED].#76's September 2020 MAR indicated [REDACTED]. His oxygen saturation was documented as 96%. Observation and interview on 09/08/2020 at 9:57 AM, Resident #76 said he was doing fine. He was receiving oxygen via nasal cannula. The oxygen concentrator was set at 8 liters per minute. Observation and interview on 09/09/2020 at 8:30 AM, revealed Resident #76's nasal cannula tubing was dated 08/27/2020. Oxygen was set at 4 liters per minute. RN A said the date written was 8/27 and that was too old and should have been changed. RN A said all nurses were

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) responsible for checking oxygen settings. When asked about Resident #76's oxygen setting on the morning of 09/08/2020, she said it was set at 6-7 liters per minute and she decreased it to 4 liters per minute at that time. When asked what Resident #76 physician order for [REDACTED].#76's oxygen was set at 4 liters per minute and the nurses were responsible for setting oxygen. She said it would be herself and the other night nurse who were responsible for setting the oxygen. When asked how often she checked the oxygen, she said, every now and then. When asked how she knew what to set oxygen at, she said she checked the orders in computer. Resident #21 Record review of Resident #21's admission record revealed she was 84-years-old and was re-admitted to the facility on [DATE]. She was originally admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #21's care plan initiated 03/15/18 and revised on 01/28/20 revealed: -Focus: Resident #21 is at risk for impaired gas exchange r/t [MEDICAL CONDITION], respiratory illness -Goal: Will have no signs and symptoms of poor oxygen absorption through the review date -Intervention: oxygen at 2 liters per minute via nasal cannula Record review of Resident #21's annual MDS dated [DATE] revealed her BIMS was scored 15 out of 15 to indicating her cognition was intact. She required extensive assistance of one staff for dressing, toilet use and personal hygiene. She required extensive assistance of two staff for bed mobility and was total dependence for transfers. She was always incontinent of bladder and bowel. She required oxygen therapy for respiratory treatments while a resident. Record review of Resident #21's active physician order summary report as of 09/11/2020, revealed an order for [REDACTED]. Record review of Resident #21's September 2020 MAR indicated [REDACTED]. Observation on 09/09/2020 at 9:00 AM, revealed Resident #21 had a nasal cannula and oxygen concentrator was set at 6 liters per minute. Observation on 09/09/2020 at 9:41 AM, revealed Resident #21 had a nasal cannula on and oxygen concentrator was set at 6 liters per minute. She was sleeping in bed. In an interview on 09/10/2020 at 1:35 PM, when asked how correct oxygen settings were communicated from one staff to another, RN A she said the information was on the MAR. In an interview on 09/11/2020 at 10:30 AM, the DON said nurses were supposed to do rounds at beginning of each shift to make sure oxygen settings were correct. The nurses were to compare the settings with MD orders. When asked what could happen to a resident if you discover an oxygen setting was set high at 6-8 liters per minute, she said the carbon [MEDICATION NAME] level could rise and resident could become confused. She said sometimes residents would reach over and turn the dial up themselves if they felt the need for more oxygen. When asked when should nasal cannulas be changed, she said nursing staff should follow MD orders and they were to be changed every week on night shift. If the policy and procedure was different than the physician orders, the MD order should always be followed. Requested policy and procedure for Oxygen on 09/10/2020 at 3:15 PM from the Administrator and DON and received the following: Record review of the facility policy titled: Infection control policy/procedure, use of oxygen revised 05/2007 revealed: Policy: It is the policy of this facility to promote resident safety in administering oxygen Procedures: The following guidelines will be observed in oxygen administration. 1. The oxygen cannula or mask does not require scheduled changing when used on one resident. It should be changed when soiled or dirty . Continued review of the facility policy revealed it did not identify the procedure for oxygen administration.
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** Based on 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 for one of six residents (Resident #72) reviewed for pharmacy services in that: -Resident #72 was not administered three medications on 09/09/2020 as ordered by the physician. This failure could place all residents at risk for not receiving the therapeutic benefits of their medications. Findings Include: Record review of Resident #72's admission record revealed she was [AGE] years old and was re-admitted to the facility on [DATE]. She was originally admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. History to include gastrostomy malfunction, dysphagia, gastro-[MEDICAL CONDITION] reflux disease (GERD), pneumonia, acute [MEDICAL CONDITION] with [MEDICAL CONDITIONS], hypertensive heart and [MEDICAL CONDITION]. Record review of Resident #72's physician progress notes [REDACTED].#72's care plan date initiated 04/28/2018 and revised on 10/28/2019 revealed the following care plan: -Focus: Resident #72 is at risk for discomfort related to [MEDICAL CONDITION]([MEDICAL CONDITION] Reflux Diseases). -Goal: Will remain free from discomfort, complications or signs and symptoms related to dx [MEDICAL CONDITION] review date. Interventions included: give medications as ordered . -Focus: Resident #72 has limited physical mobility related to pain in right knee, [MEDICAL CONDITION], weakness. -Goal: Will maintain current level of mobility through review date. -Interventions included provide gentle range of motion as tolerated with daily care and did not include administer medication as ordered. -Focus: Resident at risk for impaired gas exchange related to a [DIAGNOSES REDACTED]. -Interventions included: Give aerosol or [MEDICATION NAME] as ordered. -Focus: Resident is at risk for ineffective respiratory exchange related to a [DIAGNOSES REDACTED]. -Interventions included: Administer medication/puffers as ordered . Record review of Resident #72's quarterly Minimum Data set ((MDS) dated [DATE] revealed her Brief Interview for Mental status (BIMS) was scored 15 out of 15, indicating her cognition was intact. The resident required extensive assistance of one staff for her bed mobility, transfers and toilet use. She was occasionally incontinent of bladder and bowel. Record review of Resident #72's active physician order [REDACTED]. -Aspercreme Lotion 10% ([MEDICATION NAME]) Apply to knees topically two times a day for knee pain. Start date 03/11/2020. -[MEDICATION NAME] Aerosol 18-130 micrograms/ACT ([MEDICATION NAME]-[MEDICATION NAME]), 2 puffs inhale orally four times a day for shortness of breath. Start date 07/31/2020. Record review of Resident #72, Medication Administration Record [REDACTED]. -[MEDICATION NAME] tablet 20 milligrams: scheduled 8:00 AM and 4:00 PM. -[MEDICATION NAME] Aerosol 18-130 micrograms/ACT([MEDICATION NAME]-[MEDICATION NAME]) 2 puffs inhale orally every 12 hours for Asthma: scheduled 9:00 AM and 9:00 PM. Observation on 09/09/2020 at 8:00 AM, revealed RN A administering all 8:00 AM and 9:00 AM medications to Resident #72 except for [MEDICATION NAME] 20 milligrams tablet, Aspercreme Lotion 10% and [MEDICATION NAME] inhaler. In an interview on 09/09/2020 at 1:00 PM, Resident #72 said she did not receive Aspercreme in the morning. She said she was told it is on order. In an interview and observation on 09/09/2020 at 1:15 PM, RN A said she thought she gave the [MEDICATION NAME] to Resident #72. She was searching for the blister pack in the med cart and did not find it. She said she did not give it. She said the Aspercreme was on order and that she did not give the Aspercreme. She searched the medication cart for Resident #72's [MEDICATION NAME] inhaler. She said the medications probably ran out yesterday and was not reordered. When asked why the medications were documented as administered by you in the MAR, she said Sorry, I was just going down the list and checking as I was talking to you (Surveyor). In an interview on 09/10/2020 at 9:05 AM, when asked how she knew when to reorder medications, LVN B said when the pills on the blister pack get to the blue column this was the indicator to reorder. She said, for inhalers, she would reorder according to the number of clicks left and that other inhalers were metered. In an interview on 09/11/2020 at 10:30 AM, when asked what nurses were supposed to do if they documented medications as given but were not actually given, the DON said the nurse would need to notify physician about the missed dose and write a medication error report. Record review of facility policy and procedure titled Section: Medication Administration, Subject: Medication Administration-Oral, revised 05/2018 and read in part: Policy: It is the policy of this facility to accurately prepare, administer and document oral medications. Procedures: Equipment: Medication Book or EMAR (Computer) .Medications .Preparing non-unit dose medications: [REDACTED].and check label with medication card .

F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 that the medication error rate was not five percent or greater. The facility had a medication error rate of 6%, based on three errors out of 49 opportunities, which involved one of six residents (Resident #72) and one of four staff (RN A) reviewed for medication administration. -RN A failed to administer three morning medications due on 09/09/2020 as ordered by the physician. These failures could affect all residents by placing them at risk of not receiving their medications as ordered by the physician which could result in a decline in their health and well-being. Findings include: Record review of Resident #72's admission record revealed she was [AGE] years old who was re-admitted to the facility on [DATE]. She was originally admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. History to include gastrostomy malfunction, dysphagia, gastro-[MEDICAL CONDITION] reflux disease (GERD), pneumonia, acute [MEDICAL CONDITION] with [MEDICAL CONDITIONS], hypertensive heart and [MEDICAL CONDITION]. Record review of Resident #72's physician progress notes [REDACTED]. Assessment & Plan: GERD-established problem-increase [MEDICATION NAME] to 20 milligrams twice daily (note: [MEDICATION NAME] is brand name for [MEDICATION NAME]) Record review

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) of Resident #72's care plan date initiated 04/28/2018 and revised on 10/28/2019 revealed the following care plan: -Focus: Resident #72 is at risk for discomfort related to [MEDICAL CONDITION]([MEDICAL CONDITION] Reflux Diseases). -Goal: Will remain free from discomfort, complications or signs and symptoms related to the [DIAGNOSES REDACTED]. Interventions included: give medications as ordered . -Focus: Resident #72 has limited physical mobility related to pain in right knee, [MEDICAL CONDITION], weakness. -Goal: Will maintain current level of mobility through review date. -Interventions included provide gentle range of motion as tolerated with daily care and did not include administer medication as ordered. -Focus: Resident at risk for impaired gas exchange related to the [DIAGNOSES REDACTED]. -Interventions included: Give aerosol or [MEDICATION NAME] as ordered. -Focus: Resident is at risk for ineffective respiratory exchange related to the [DIAGNOSES REDACTED]. -Interventions included: Administer medication/puffers as ordered . Record review of Resident #72's quarterly Minimum Data set ((MDS) dated [DATE] revealed her Brief Interview for Mental status (BIMS) was scored 15 out of 15 indicating her cognition was intact. She required extensive assistance of one staff for her bed mobility, transfers and toilet use. She was occasionally incontinent of bladder and bowel. Record review of Resident #72's active physician order [REDACTED]. -Aspercreme Lotion 10% ([MEDICATION NAME]) Apply to knees topically two times a day for knee pain. Start date 03/11/2020. -[MEDICATION NAME] Aerosol 18-130 micrograms/ACT([MEDICATION NAME]-[MEDICATION NAME]), 2 puffs inhale orally four times a day for shortness of breath. Start date 07/31/2020. Record review of Resident #72, Medication Administration Record [REDACTED]. -[MEDICATION NAME] tablet 20 milligrams: scheduled 8:00 AM and 4:00 PM. -[MEDICATION NAME] Aerosol 18-130 micrograms/ACT ([MEDICATION NAME]-[MEDICATION NAME]) 2 puffs inhale orally every 12 hours for Asthma: scheduled 9:00 AM and 9:00 PM. Observation on 09/09/2020 at 8:00 AM, revealed RN A administered all 8:00 AM and 9:00 AM medications to Resident #72 except for [MEDICATION NAME] 20 milligrams tablet, Aspercreme Lotion 10% and [MEDICATION NAME] inhaler. In an interview on 09/09/2020 at 1:00 PM, Resident #72 said she did not receive Aspercreme in the morning. She said she was told it is on order. In an interview and observation on 09/09/2020 at 1:15 PM, RN A said she thought she gave the [MEDICATION NAME] to Resident #72. She searched for the blister pack in the med cart and did not find it. She said she did not give it. She said the Aspercreme was on order and that she did not give the Aspercreme. She searched the med cart for Resident #72's [MEDICATION NAME] inhaler. She said the medications probably ran out yesterday and was not reordered. When asked why were they checked by you in the MAR indicated [REDACTED]. In an interview on 09/10/2020 at 9:05 AM, when asked how she knew to reorder medications, LVN B said when the pills on the blister pack got to the blue column this is the indicator to reorder. She said for inhalers she would reorder according to the number of clicks left and that other inhalers were metered. In an interview on 09/11/2020 at 10:30 AM, when asked what are nurses supposed to do if they documented medications as given but were not actually given, the DON said the nurse would need to notify MD of the missed dose and write a medication error report. Record review of facility policy and procedure titled Section: Medication Administration, Subject: Medication Administration- Oral, revised 05/2018 and read in part: Policy: It is the policy of this facility to accurately prepare, administer and document oral medications. Procedures: Equipment: Medication Book or EMAR (Computer) .Medications .Preparing non-unit dose medications: [REDACTED].and check label with medication card .
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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, interview, and record review, the facility failed to ensure that drugs and biologicals used in the facility were secured in locked compartments for four of five medication carts reviewed for drug storage as evidenced by: - The facility failed to ensure the 200 Hall medication cart used by MAs was free of unsecured medications; - The facility failed to ensure the 300 hall Nurse Medication cart was free of unsecured medications and expired medications; -The facility failed to ensure the 200 Hall Nurse Medication cart was free of expired medications and unwrapped saline syringes; -The facility failed to ensure the 100 Hall Nurse Medication cart was free of expired medications and medications with incomplete pharmacy labels. These failures could affect residents receiving medications, placing them at risk of having medication potency that could cause a decline in health status, receiving the wrong medication, treatment, drug diversion and death. Findings include: Observation and interview of medication aid cart 200 Hall on 09/10/2020 at 8:45 AM revealed in the bottom of second drawer one loose yellow, round pill with L113 and 20 etched on it. MA A said she is in charge of keeping the cart clean and organized when and the nurses do the auditing. She said she will take pill to her nurse for further advise on it's disposition. She said the pill was a [MEDICATION NAME]. Observation and interview of nurse medication cart 200 Hall on 09/09/2020 at 9:05 AM revealed a bottle of over the counter Gericare multi vitamin with expiration date 8/2020 and one 30 ml syringe of normal saline without it's outer plastic package. LVN B said the syringe should not be there and she will take the medications to the med room and place in destruction bin. She said she is in charge of auditing her cart and the DON will audit as well. Observation and interview of nurse medication cart 100 Hall on 09/09/2020 at 9:10 AM revealed a tube of [MEDICATION NAME] Cream with a partial pharmacy label and no name label. There was a tube of [MEDICATION NAME] Sodium Topical gel 1% with partial pharmacy label and no name label. There was a single Aspercreme/[MEDICATION NAME] with expired date 06/19. When asked what she will do with these medications, RN B said she will take them to the med room where the destruction bin is kept and put it in there. RN B said the pharmacist comes every month to audit the carts. Observation and interview of nurse medication cart 300 Hall on 09/09/2020 at 9:25 AM revealed in the second drawer one loose yellow, round pill etched with TEVA. There was a bottle of [MEDICATION NAME] Lotion 0.1% expired 2/20. RN A said she will take these to the destruction bin in the med room. Record review of facility policy and procedure for Medication Access and Storage, revised 05/2020 revealed in part: Policy: It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications: [REDACTED]. Medications labeled for individual residents are stored separately from floor stock medications 13. Medication storage areas are kept clean, well lit and free of clutter. Continued review of the facility policy revealed it did not identify the policy/procedure for expired medications or loose medications.
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 and interview the facility failed to implement an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections; in that: - CNA T failed to change gloves during Resident #32's incontinent care. - CNA S entered the isolation unit without donning proper PPE. - RN-C did not perform correct hand hygiene procedures when dispensing of medication. - CNA S contaminated the resident's sink when rinsing a urinal after emptying. These failures could affect all residents, placing them at risk for spread of infection. Findings included: Resident #32 Record review of Resident #32's admission record revealed he was [AGE] years old and was admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #32's annual MDS dated [DATE] revealed his BIMS was scored 2 out of 15 to indicate he had severe cognitive impairment. He was totally dependent on one staff assistance for bed mobility, transfers, dressing and personal hygiene. He was always incontinent of bladder and bowel. Record review of Resident #32's care plan revealed the following focus areas: -Focus: Resident is at risk for an ADL Self Care Performance Deficit related to limited physical mobility as evidenced by (aeb) right side [MEDICAL CONDITION] and history of (h/o) cerebral infarction. Resident is bed bound per his choice. Date initiated 03/21/2019. -Goal: Will maintain current level of function in all ADLs through the review date. -Interventions included: Toilet use: totally dependent on staff for toilet use. Has contractures of the right side. Provide skin care to keep clean and prevent skin breakdown . -Focus: Resident has bowel/bladder incontinence. Date initiated 10/03/2016. -Goal: Will remain free from skin breakdown due to incontinence and brief use though the review date. -Intervention to include: Brief use: uses disposable briefs frequently and PRN. Incontinent: check as required for incontinence. Wash rinse and dry perineum Observation of incontinent care for Resident #32 and interview on 09/11/2020 at 8:55 AM revealed CNA T did not remove soiled gloves, perform hand hygiene and put on clean gloves after handling soiled briefs and before touching clean briefs. When asked why she did not change gloves, perform hand hygiene after cleaning all before handling clean the adult

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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 -** Some	(continued... from page 3) brief, she said yes she should have changed gloves and put on clean ones at that point. When asked what is done after removing used gloves, she said that she would wash hher ands and then put on new gloves. In an interview on 09/11/2020 at 10:30 AM, the DON said she expected nursing staff to clean the resident, dispose of soiled brief and gloves, then wash hands or hand sanitize and then put on clean gloves prior to securing clean adult briefs onto a resident during incontinent care. When asked why this was done, she said because it was prudent for nursing staff to wash their hands after performing a dirty task and prior to performing a clean task Observation and interview on 9/10/2020 at 9:40 AM revealed CNA S entering the isolation unit without first going to the PPE donning area and donning a gown and face shield. She wore only a face covering mask. She remained in unit for approximately five minutes at nurses station and then entered donning area to put on protection gown. When asked why she did not put on PPE first, CNA S stated that she was waiting for more PPE to arrive from the laundry. Observation and interview on 9/10/2020 at 9:55 AM revealed RN-C placing Resident #41's medications into medication cup. RN-C placed Resident #41's OTC (over the counter) medications in cap of bottle prior to placing in medication cup. RN-C punched medications from blister packs directly into the gloved palm of his hand, and using gloved fingertips to place medication into cup. RN-C adjusted his facial mask several times during the process and did not change his gloves at any time. RN-C did not change his gloves before entering Resident #41's room or prior to giving medication cup to Resident #41. When asked why he placed medications in the palm of his contaminated hand, RN-C stated he did it this way so the medications would not fly off. Observation and interview on 9/10/2020 at 12:30 PM revealed CNA S empty Resident #40's urine collection bag into a urinal. CNA S then emptied the urinal into commode and then rinsed the urinal with water from sink faucet, contaminating the faucet with the rim of the urinal. When asked why she used the sink to wash the urinal, CNA S she said nothing. When asked what she should do about the contaminated faucet, she said I can go get something to clean it with. She returned with a dry face cloth, turned on the faucet to wet the cloth, and started to wipe the the faucet. When asked what was on the cloth, she said she was just going wipe the faucet. Record review of facility policy and procedure titled: Routine procedures, hand washing revised 05/2007 revealed: Policy: It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. Purpose: Hand washing is generally considered the most important single procedure for preventing nosocomial infections . Record review of facility policy and procedure titled: Routine procedures, Incontinent care, revealed: Policy: It is the policy of this facility to: 1. Remove urine or feces from skin. 2. Cleanse and lubricate skin. 3. Provide dry, odor free [MEDICATION NAME] care system. Procedures: .4. D. Cleanse perineal/rectal area and apply a new brief Continued review of the facility policy revealed it did not identify when to perform hand hygiene or when to don or doff gloves during incontinent care.