STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32677 Based on observation, interview and record review, the facility failed to accommodate the needs and preferences for 4 of 20 residents (Resident #5, #6, #7, #8) reviewed for accommodation of needs. --The facility did not provide Resident #5 with incontinent care for more than 10 hours on 6/28/22. Resident #5 was incontinent of urine and bowels and required assistance with ADLs. Resident #5's brief was saturated with urine and feces and the lymphedema fluid was leaking through her skin. -Resident #5 was not provided showers and was told that because she was obese, she could only receive bed baths. -The facility did not provide Resident #6 with showers and she was told that she could only receive bed baths because she was obese. -The facility failed to maintain the a/c in good repair -The facility failed to ensure the rooms were in adequate temperature These failures placed residents who were dependent on staff for toileting and bathing at risk for embarrassment, rashes, infections, discomfort, and skin break down. Findings included: Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year-old female who admitted to the facility on 1/9/21 and readmitted on [DATE] whose diagnosis included hypertensive heart disease with heart failure (high blood pressure), hypothyroidism (thyroid gland does not produce enough hormones), morbid obesity due to excess calories, lymphedema (tissue swelling caused by protein rich fluid), muscle weakness, chronic pain syndrome, and problem related to care provider dependency. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's MDS dated [DATE] revealed a BIMS Summary score of 15 (cognitively intact); She did not have any behaviors, required extensive assistance with two person assist for bed mobility, transfer; walking in room, corridor and locomotion off unit did not occur; locomotion on unit occurred once or twice with two person assist; extensive assist with one person physical assist with dressing, toilet use and personal hygiene; and she was totally dependent on staff with two person assist with bathing. She was frequently incontinent of urine and bowel, and resident weight was 566 lbs. Record review of Resident #5's Care Plan dated 4/13/22 indicated Resident #5 was incontinent of bowel/bladder, interventions were to check the resident as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes; Risk for skin breakdown route of decreased mobility, incontinence, lymphedema with interventions as encourage resident and provide assistance to turn and reposition every 2 hours and PRN comfort and follow facility policies/protocols for the prevention/treatment of skin breakdown, notify MD and wound care nurse as appropriate and implement ordered interventions, observe skin when providing care for redness, open area and notify Nurse, provide assistance for toileting/incontinence checks every 2 hours and PRN. Provide peri-care, buttocks are post incontinent episode per facility policy, provide shower/bed bath per schedule and PRN .; She has an ADL self-care performance deficit route of Activity intolerance, impaired balance, limited mobility, pain and interventions were bathing/showering: The resident requires (Total dependence) by (1-2) staff with bathing/showering (3 times) and as necessary, bed mobility: the resident requires (extensive assistance) by (1-2) staff to turn and reposition in bed. Dressing: The resident requires (extensive assistance) by (1-2) staff to dress. Eating: The resident requires (Supervision) by (1) staff to eat . Personal Hygiene: The resident requires (Supervision) by (1) staff with personal hygiene and oral care. Toilet use: The resident requires (Extensive assistance) by (1-2) staff for toileting. Transfer: The resident requires (Extensive assistance) by (1-2) staff to move between surfaces. Focus: Limited physical mobility route of decrease in functional mobility, obesity, lymphedema, weakness with interventions being locomotion: The resident requires (Extensive assistance) by (1) staff for locomotion using (wheelchair). Observation and interview on 6/28/22 at 11:35 a.m. with Resident #5 she was observed lying in bed and it was warm in the room and there was an odor of feces. Resident was observed to be obese, and she said things have not been good at the facility lately. She said someone in the facility keeps turning the heat on and she told the ED about it. Resident #5 said the air conditioner was broken before and the ED got it fixed, but in the last 2 weeks it was too hot in the room. Observation revealed an odor in the room. She said they don't give her deodorant or the basics, they have to buy their own. The doctor said she had to use name brand soaps and lotion, and the unscented soaps Resident #5 said she has not been cleaned up yet. Her bath aides normally come after lunch time. She said MWF are her bath days, but she is a big girl and needs to bathe daily. Her briefs have not been changed today. She said CNA, changed her today at 2:30 a.m. and that was the last time anyone had changed her. Resident #5 said she had requested in the past to get baths daily, but they said they only bathe the 3 days. They give her bed baths when they bathe her. She asked them to take her to the shower, but they have to use the Hoyer lift. They said that for her it was too much for them to take her to the shower. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/28/22 at 12 p.m. with Resident #5 and ADON revealed it was warm in Resident #5 room. Observation revealed there were 2 fans on (tower fan and a box fan in the room). Temperature revealed 80 degrees in Resident #5 room. At 12:11 p.m. Resident #5 pressed her call light and ADON responded and said on the other side of the building it was too cold and this side of the facility it is warm. She said some rooms on Hall 300 there were different temperatures and thermometers. ADON said residents are changed every 2 hrs. Resident #5 answered the ADON saying she was not changed every 2 hrs. and ADON did check Resident #5's brief and observation with ADON revealed a bubble of fluid on the resident's side on leg that was leaking. The ADON said Resident #5 brief was soaked with urine and feces. ADON asked Resident #5 if she called anyone to change her and she said yes, and that CNA D was her aide. She had the light on, and one of the nurses answered and said CNA D was her nurse. The ADON said when the aide comes on shift, they are supposed to come to introduce herself to the resident. The Nurse turned the light off. ADON checked Resident #5's briefs at this time and said the resident did have a bowel movement. It is not the resident's responsibility to call for the staff they should come every 2 hours. She wanted to know who answered the light and who she called to answer the light to help the resident. The ADON said Resident #5 preferred bed baths. Resident #5 said no she never said that, and that she was told they did not have anyone to take her to the shower. The ADON said she has to follow up to see if they can get the equipment to take her to the shower. Resident #5 said a former CNA took her to the shower. Resident said she has all the equipment she needs to be able to get the shower. The ADON said Resident #5 has to work with therapy to train on how to transfer from the bed to the shower and bring her back. Safety first. She had a shower last year. She has been getting bed baths. She had a bed bath yesterday. Observation on 6/28/22 at 12:22 with ADON revealed the thermostat for Resident #5's room was set on 80 degrees. All the other thermostats were set on 75 degrees. The ADON was observed changing the thermostat to 75 degrees. Observation and Interview on 6/28/22 at 12:42 p.m. with Assistant Maintenance Director he was observed changing the temperature for Resident #5's room to 75 from 76. The thermostat at 12:47 p.m. says 76 degrees for rooms 337 to 325. Maintenance said he was not sure which thermostat was for what room for sure because he would have to go to the roof to find out. Interview on 6/28/22 at 1:21 p.m. with CNA D she said she came in at 6 a.m. and she leaves 6 p.m. CNA D said she knocked on Resident #5's door this morning and said this is CNA D and let her know she would be the CNA today and she went to pass the trays. It was supposed to be 3 CNA's, but they found out it was only 2 staff. CNA D said the CNA's started changing residents and halfway through breakfast they feed people. Her call light was on, and the nurse went in and saw the light and said Resident #5 did not need anything. She said the nurse said Resident #5 said she did not need to be changed yet. The first shift left at 6 a.m. They are supposed to go every 2 hours. She went in to check on the resident before lunch and she said she was ok. She says she did not check the time. It was between 10 and 11 a.m. Resident did not have that bowel movement before when she went in to check the resident. The residents have a right to ask for a bath whenever they want, and they have to give it to them. CNA D said this was her 3rd week working at the facility. CNA D said she does not mind giving the resident a shower, but they need a secure shower bed or chair for her. She said she cannot just get Resident #5 up; they need to make sure it is solid enough to support her weight. CNA D said Resident #5 loves her bath. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 7/6/22 at 12:40 p.m. with CNA E came to give Resident #5 her bed bath. CNA E said Resident #5 always says she wants to take a bath or go to the shower. CNA E said the nurses say they don't have a good enough Hoyer pad for her, so they just give her a bed bath. Interview on 7/6/22 at 3:41 p.m. never refused therapy at any time. She cooperated with PT. The resident did make progress. Made bed mobility activities. Sitting at edge of bed sit to stand as much as tolerated. She can only bear wait for short times. She has a boot that was modified for her. Once a week to stand and twice a week sit at edge of bed. She is not able to come out of her room. Interview on 7/6/22 at 3:50 p.m. with Director of Physical Therapy (PT) she said the first Resident #5 was seen was on 1/20/21 and ended on 2/9/21. During this time, Resident #5 had not gotten out the bed, but they got Resident #5 custom braces. She said from 4/25/22 to 5/25/22 was the last time Physical Therapy and she discharged with her bed mobility was at minimum assistance and she was able to move to sitting at the edge of bed with Moderate assistance. Resident #5's dynamic sitting was standing by assistance to contact guard assistance standing beside her to make sure she does not lose her balance. She said Resident #5 worked on standing with a walker and 2 people assisting her. She said Physical Therapy saw Resident #5, 7 times, and she has always been cooperative. Physical Therapy did not do showers with Resident #5 because Nursing does the showers. She said they would not have an objection to Resident #5 getting a shower and she is capable of washing her upper body by herself. Resident #6 Record review of Resident #6's face sheet revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] whose diagnosis included chronic respiratory with hypoxia (severe pneumonia with problems with breathing), critical illness myopathy (disease of limb and respiratory disease), atrial fibrillation (irregular fast heart beat), tracheostomy (whole in windpipe to help with breathing), diabetes mellitus (blood sugar), hypomagnesemia (electrolyte disturbance due to low level of serum magnesium), and morbid (severe) obesity with alveolar hypoventilation (person does not take enough breaths per minute). Record review of Resident #6's MDS dated [DATE] revealed a BIMS Summary score of 15 (cognitively intact). Walking in room and corridor did not occur, she was totally dependent with two staff assisting for transferring, dressing, toilet use and personal hygiene, totally dependent with one staff assisting for locomotion on and off the unit, extensive assistance with two staff assisting with bed mobility and totally dependent with one staff for bathing. She weighed 630 lbs. Resident was not rated for urinary continence and she was always incontinent of bowel. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's Care Plan dated 6/2/22 indicated Resident #6 requested 2 briefs on at all times, interventions were to check frequently as required for incontinence; history of resisting/refusing care with incontinent care and weights at times, interventions were do not rush resident when providing care and educate resident on importance of letting staff provide/assist with care allowing staff to performing incontinent care ; ADL self-care deficit performance deficit r/t Activity Intolerance, Confusion, Impaired balance, Limited Mobility, lack of coordination, muscle wasting and atrophy, interventions were bathing/showering required (Total Dependence) by (1) staff (3x a week) and as necessary, bed mobility (Extensive assistance) by (1-2) staff to turn and reposition in bed, dressing (Extensive assistance) by (1-2), eating (Supervision) by (1) staff, personal hygiene and oral care (Extensive assistance) by (1-2) staff and oral care, toilet use (Total dependence) by (1-2) staff, transfer (Extensive assistance) by (1-2) staff, encourage the resident to participate to the fullest extent possible with each interaction; potential impairment to skin integrity r/t decreased mobility, incontinence, interventions were avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; bowel/ bladder incontinence r/t Activity Intolerance, Impaired Mobility encourage fluids during the day to promote prompted voiding responses, incontinent: Check frequently and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Interview on 7/6/22 at 2:40 p.m. with Resident #6 she said the temperature has been ok, but she likes it a little colder. She said she knew that the elderly does not like it that cool. Resident #6 was observed to be obese. Resident #6 was observed to have a little portable a/c. Observation revealed the temperature was 76 with the portable a/c blowing. Resident #6 said somebody on the night shift changed the a/c and made it warm and was not changing the a/c back. She said she spoke out and said it was warm in her room and they changed the temperature back. Resident #6 she said she wants to take a shower, but they don't have a chair big enough for her and they don't have a chair big enough to get her there. Her wheelchair just came in last week. They did not have anything to transport her. They give her bed baths. Resident #6 said she was told that she could not take a shower. Resident #7 Record review of Resident #7's face sheet revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] whose diagnosis included dementia (loss of cognitive functioning), atherosclerotic heart disease (buildup of fat, cholesterol, and other substances) , dysphagia (difficulty swallowing), polyneuropathy (malfunction of many nerves throughout the body), and major depression (dark consuming mood). Record review of Resident #7's MDS dated [DATE] revealed a BIMS Summary score of 5 (severely impaired). Walking in room and on corridor did not occur, locomotion on and off the unit only occurred once or twice, extensive assistance with one staff assisting for bed mobility, dressing, toilet use and personal hygiene, transfers required two staff assisting, limited assistance was needed for eating and bathing required supervision by one staff. She was always incontinent of bowel and bladder. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's Care Plan dated 5/24/22 indicated Resident #7 dependent on staff for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits, Physical Limitations and interventions were all staff to converse with resident while providing care. Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, meals. Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. The resident needs assistance with ADLs as required during the activity. The resident needs 1:1 bedside/in-room visits and activities if unable to attend out of room events; ADL self-care performance deficit r/t Dementia, Impaired balance, muscle BATHING/SHOWERING: The resident requires (Extensive assistance) by (1) staff with bathing/showering (3x a week) and as necessary. BED MOBILITY: The resident requires (Extensive assistance) by (1) staff to turn and reposition in bed. DRESSING: The resident requires (Extensive assistance) by (1) staff to dress weakness, IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY, POLYNEUROPATHY with interventions, EATING: The resident requires (Supervision assistance with set up) by (1) staff to eat. PERSONAL HYGIENE: The resident requires (Extensive assistance) by (1) staff with personal hygiene and oral care. TOILET USE: The resident requires (Extensive assistance) by (1) staff for toileting. TRANSFER: The resident requires (Limited assistance) by (1) staff to move between surfaces, impaired cognitive function and is at risk for further decline due to Dementia. Observation and attempted interview on 6/28/22 at 12:25 p.m. of Resident #7's room was 80 degrees. Resident #7 would not speak. Resident #8 Record review of Resident #8's face sheet revealed a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE] whose diagnosis included acute respiratory failure with hypoxia (not enough oxygen in the blood), morbid obesity with alveolar hypoventilation (defect in brains control over breathing), metabolic encephalopathy (alteration in consciousness), type 2 diabetes mellitus (blood sugar), acute kidney failure (kidney's unable to filter waste), atrial fibrillation (irregular and fast heart beat), and hypertension (high blood pressure). Record review of Resident #8's MDS dated [DATE] revealed a BIMS Summary score of 15 (cognitively intact); transfers, walking in room, walking in room and corridor, locomotion on and off the unit did not occur, dressing occurred once or twice with one staff physical assisting, he was totally dependent on 1 staff physically assisting for bed mobility, he needed extensive assistance with one staff assisting for toilet use, personal hygiene, and bathing required physical help limited to transfer with one staff assisting. Resident #8 weighed 408 lbs. Interview on 8/4/22 at 12:30 p.m. with Resident #8 he said the temperature in his room was comfortable and that he enjoyed living at the NF. Resident #8 said at one time when he had the COVID-19 he was placed on the hot zone and experienced the temperature being hot in his room. Resident said he mentioned it to the nurse who name who could not remember. Resident said the nurse told him that the NF was working on the issue. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/30/22 at 12:21 p.m. with Administrator he said on 6/17/22 the air conditioner (a/c) was broken right outside the door by the kitchen (blower out), and he was told it would be a 2 week wait. He said the a/c was fixed on 6/17/22 for 300 Hall and the blower went out by kitchen. He could not recall when the a/c went out for the 300 Hall. For the one that was broken now they have an estimate for that, and they said it would take 2 weeks to come in. When asked why it was warm by SW office, he said he noticed it was warm there so he will ask maintenance what is going on. Interview on 6/30/22 at 12:45 p.m. with Maintenance he said the facility had the a/c set so low the pipes had frozen over, and it was cutting the fans on and off. He had to cut it off and he thinks that it needs more freon for the front office in the front hallway. Interview on 6/30/22 at 12:51 p.m. with Maintenance he said the a/c was broken on 6/29/22 by the front office. He said the facility did not have a quote for this one yet. Maintenance said he was on vacation when the 300 Hall a/c went out. The dining room a/c went out on the same day they fixed the 300 Hall. Interview on 6/30/22 at 3:10 p.m. with CNA F she said she thought the a/c was broken because it was warm. She said when she was working on 300 Hall, some of the residents were transferred to other rooms. Resident #8 was moved because he kept saying it was hot in his room. CNA F said Resident #5 said it was hot in her room and was not moved. Interview on 6/30/22 at 12:54 p.m. with local a/c company revealed the a/c on 300 Hall was fixed on 6/17/22 because the compressor was out. The broken a/c was diagnosed on [DATE] to diagnose it and that took 17 days to get the part and to fix. They placed the order for the compressor, and it arrived on 6/16/22. He does not have the areas the a/c affected. The day they were changing the compressor there was another fail and they are getting pricing ready to come back to the facility again. Interview on 6/30/22 at 1:04 p.m. with Maintenance he said some of the residents changed rooms so they would not be too hot. Maintenance said it was too far away from the Nurse station to be Resident #5 room, but he does not know which thermostats or a/c affected each room. Interview on 6/30/22 at 1:09 p.m. with the Administrator he said the resident who had no a/c was moved to another room. Resident #5 was not moved so they gave her a fan and the other residents who were not moved were given fans to keep them cool while they waited for the repair and the part to come in. Interview on 7/6/22 at 12:15 p.m. with CNA E she said she has worked at the facility for 5 or 6 months and it had been warm here on the 300 Hall. CNA E said the thermostat had been going out, but it is warm in certain sections like the back of 300 Hall that stays warm. CNA E said the hot rooms are Resident #5, Resident #6, Resident #7, Resident #8. CNA E said she gets a cool small towel and rinse it and rub the resident's faces. She said if the resident wants her to, she will open the window or put them in a wheelchair to let them come out into the cool air. Observation revealed the temperature in room [ROOM NUMBER] was 77 degrees at this time and no one was in the room at this time. CNA E and this Surveyor could not feel the a/c on. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/6/22 at 12:40 p.m. with Resident #5 and CNA E she said it has been hot in Resident #5's room since the beginning of summer. One of the Nurses turned on the heat. said the a/c was broken and he came and told her the air was fixed. The CNA said the facility did not give Resident #5 or any of the other resident's extra water and Resident #5 kept asking people for ice. Resident #5 said sometimes she goes all day without ice, and she has to beg different ones for ice. Resident #5 said on the weekends the Staff walk around with fans because it is so hot. Resident #5 said the Staff do not take her temperature. CNA E said the staff were not taking Resident #5's temperature, only when they do blood pressure. CNA E said she has found Resident #5's room with the heat on. The CNA E said the facility did not do anything for the residents when the a/c was broken. CNA E said the Administrator came to Resident #5's room and they are moving her because on Tuesday, 7/5/22 he came and took her temperature and it showed her room temperature was too hot. They will move her to the 200 Hall by the shower. CNA E and Resident #5 said the only time maintenance came to Resident #5's room was when the bed was broken and she found out that someone had pulled the plug out of the wall. Further interview on 7/6/22 at 1:05 p.m. with CNA E she said 336 was moved to 323 because he was burning up down that way. CNA E said it was scorching hot in the room and it was the weekend. CNA E said they did not do ice water every 2 hrs. CNA E said they did not do anything extra. Record review of in-service dated 6/20/22, Topic: Staff and thermostat by Administrator revealed, The staff should not change the temperature to the thermostat unless directed by leadership. Record review of facility policy, Safe and Homelike Environment dated 1/1/22, revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and home like environment .Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents. Record review of facility's policy on Activities of Daily Living (ADLs) dated 1/1/22 revealed, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation, 3. Toileting . Record review of facility's policy on Care and Treatment of Bariatric Residents dated 1/1/22 revealed, Bariatric residents have special needs. This facility will provide the necessary care and treatment that allows the bariatric resident to remain safe and to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being .Facility still will identify equipment needs of the bariatric resident during the pre-screening and admission process. Equipment will be available upon admission for providing for the immediate needs of the resident . Considerations for equipment needs include, but are not limited to . Wheelchairs or other mobility aids, Resident lifts that can accommodate resident's size and weight, shower chairs or commodes .

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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 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** 35822 The facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet each residents medical, nursing, and mental and psychosocial needs for 1 (Resident #2) of 20 residents reviewed for care plans in that: Resident #2's care plan did not include she had a PICC/Central line Findings: Resident #2 Record review of Resident #2's face sheet revealed an [AGE] year old female admitted to the NF originally on 04/01/2022 and again on 04/22/2022 with the following diagnoses: Acute respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), pressure ulcer of the right hip stage 4, pressure ulcer of other site stage 4, non-pressure ulcer chronic of left heel and midfoot, non-pressure ulcer of right foot, bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), elevated white blood cell count, tachycardia (fast heart rate), hypoxemia (an abnormally low concentration of oxygen in the blood), and fever. Record review of Resident #2's MDS dated [DATE] revealed that Resident #2 had a BIMS score of 3 indicating she had cognition was severely impaired. Further review revealed she was totally dependent in bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. Record review of Resident #2's care plan dated 04/23/2022 did not reveal she was care planned for a PICC/central line. Record review of Resident #2's hospital records dated 04/21/2022 revealed the following: 04/19/2022 central lines: brachial vein (deep vein of the upper arm), right PICC. Observation on 06/30/2022 at 10:50am Resident #2 had a central line to her right upper arm. Record review of Resident #2's MAR revealed for the month of June 2022 normal saline flush solution use 10ml intravenously every shift for maintenance flushing of each lumen. On June 10th medication vancomycin 1 gram intravenously every 12 hours for productive cough and cellulitis for 7 days was administered June the 5th through June the 16th. Further review of Resident #2's MAR for the month of June 2022 revealed that the medication cefepime 1 gram intravenously every 8 hours for cough and cellulitis for 7 days. The medication cefepime was documented on the MAR being given June 11th through June the 17th. (continued on next page)

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	455815	A. Building B. Wing	08/04/2022

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/04/2022 at 1:32pm the MDS Coordinator said she had been working as a MDS Coordinator for Medicaid residents about a month. The MDS Coordinator said she was not sure if all the care plans for the Medicaid residents had been updated and resident centered. The MDS Coordinator said she was reviewing the residents' care plans and making corrections as needed. The MDS Coordinator said all residents care plans should be individualized and resident centered. The MDS Coordinator said if a resident had PICC/Central Line, it needed to be care planned. The MDS Coordinator said the previous Medicaid MDS Coordinator no longer worked at the NF. Interview on 08/04/2022 at 1:43pm the CNO (Corporate Nurse of Operations) said the NF had 4 different nurses that completed the MDS and care plans. The CNO said if a resident was not being care planned for a specific issue it meant the issue had been resolved. The CNO said if a resident was admitted to the NF with a PICC/Central Line, the central line should be care planned. The CNO said if the issue had not been resolved and not being care planned for, the NF had made an error. The CNO said it was important to have a resident centered care plan to provide the right care for the resident (s). The CNO said it was the DON, Corporate MDS Coordinator, and Infection Control Nurse that monitored the care plans to ensure it was being done accurately and updated when needed. Record review of the NF policy on Comprehensive Care Plans implemented on 01/01/2022 revealed in part: .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on interview and record review the facility failed to ensure services provided or arranged by the facility, as outlined by the comprehensive care plan meet profession standards of quality for 1 (CR #1) of 20 residents reviewed for professional standard in that: -The facility failed to document that medication doxycycline hyclate (antibiotic) 100mg was administered twice a day for 7 (seven) days for a bacterial skin infection. This failure placed resident at risk for bacteria to increase becoming resistant to the antibiotic and taking longer to recover from infection. Findings included: CR #1: Record review of CR #1's face sheet revealed an [AGE] year old female admitted to the NF on 06/08/2022 with the following diagnoses; acute respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), lack of coordination, pressure ulcer of the sacral, anemia (low blood) in chronic kidney disease, type 2 diabetes mellitus (too much sugar in the blood), critical illness myopathy (disease that affects the muscles), hypertension (high blood pressure), heart failure, end stage renal disease, dysphagia (difficulty swallowing), cognitive communication deficit, tracheostomy (surgical procedure that consist of making an incision in the neck to create airway), and gastrostomy (opening into the stomach for the introduction of nutrition). Records review of CR #1's MDS assessment dated [DATE] revealed resident had a BIMS score of 2 indicating resident cognition level was severely impaired. Record review of CR #1's Physician's orders dated 06/10/2022 revealed an order for doxycycline hyclate 100mg tablet give 1 (one) tablet via PEG-Tube two times a day for bacterial infection-skin. Record review of CR #1's MAR for the month of June 2022 revealed that doxycycline hyclate was initially administered on 06/10/2022 at 9:00pm. Further review revealed the days that medication doxycycline hyclate 100mg was not documented administered: -06/11/2022 at 9:00pm -06/13/2022 at 9:00am Interview on 07/13/2022 at 2:50pm via phone LVN D said she worked the 7a7p shift on 06/13/2022. LVN D was asked why she did not document or not give the medication doxycycline hyclate? LVN D said if she did not document that she gave the medication on the MAR she did not have the medication. LVN D was informed that prior to her and afterwards, it was documented that the medication doxycycline hyclate was being documented administered to CR #1. LVN D was not able to provide further explanation of the medication doxycycline hyclate and said she could not remember CR #1. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/13/2022 at 3:40pm via phone RN E said she worked the evening shift 7p-7a on 06/13/2022 and did not remember CR #1. RN E was unable to provide an explanation of why the medication doxycycline hyclate was not documented given. RN E said there must have been a glitch with the system or she thought she documented but did not. Interview 07/14/2022 at 12:15pm the Administrator said it was the DON and the Unit Managers that done the chart auditing on the residents. The Administrator said the DON was terminated due to a lack of work performance. The Administrator said it was the Corporate Nurses that were serving as interim DON. Interview on 07/14/2022 at 12:50pm the ADON/Unit Manager said she tried to do chart auditing daily by viewing the resident orders and ensuring the orders were being carried out. said according to CR #1's MAR regarding the medication doxycycline hyclate missed dosages, the Physician/NP should have been notified and see if it was okay to extend the days to ensure resident received the prescribed dosages. ADON/Unit Manager said the medication doxycycline hyclate if not documented, would be considered not given. Record review of the NF policy on Medication Administration, implemented 01/01/2022 revealed in part: .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .sign MAR after administered .correct any discrepancies and report to nurse manager .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32677 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 2 of 20 residents (Resident #5 and Resident #6) reviewed for ADLs. -The facility did not provide Resident #5 with incontinent care for more than 10 hours on 6/28/22. Resident #5 was incontinent of urine and bowels and required assistance with ADLs. Resident #5's brief was saturated with urine and feces and the lymphedema fluid was leaking through her skin. -Resident #5 was not provided showers and was told that because she was obese, she could only receive bed baths. -The facility did not provide Resident #6 with showers and she was told that she could only receive bed baths because she was obese. These failures placed residents who were dependent on staff for toileting and bathing at risk for embarrassment, rashes, infections, discomfort, and skin break down. Findings included: Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year-old female who admitted to the facility on 1/9/21 and readmitted on [DATE] whose diagnosis included hypertensive heart disease with heart failure (high blood pressure), hypothyroidism (thyroid gland does not produce enough hormones), morbid obesity due to excess calories, lymphedema (tissue swelling caused by protein rich fluid), muscle weakness, chronic pain syndrome, and problem related to care provider dependency. Record review of Resident #5's MDS dated [DATE] revealed a BIMS Summary score of 15 (cognitively intact); She did not have any behaviors, required extensive assistance with two person assist for bed mobility, transfer; walking in room, corridor and locomotion off unit did not occur; locomotion on unit occurred once or twice with two person assist; extensive assist with one person physical assist with dressing, toilet use and personal hygiene; and she was totally dependent on staff with two person assist with bathing. She was frequently incontinent of urine and bowel, and resident weight was 566 lbs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Care Plan dated 4/13/22 indicated Resident #5 was incontinent of bowel/bladder, interventions were to check the resident as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes; Risk for skin breakdown route of decreased mobility, incontinence, lymphedema with interventions as encourage resident and provide assistance to turn and reposition every 2 hours and PRN comfort and follow facility policies/protocols for the prevention/treatment of skin breakdown, notify MD and wound care nurse as appropriate and implement ordered interventions, observe skin when providing care for redness, open area and notify Nurse, provide assistance for toileting/incontinence checks every 2 hours and PRN. Provide peri-care, buttocks are post incontinent episode per facility policy, provide shower/bed bath per schedule and PRN .; She has an ADL self-care performance deficit route of Activity intolerance, impaired balance, limited mobility, pain and interventions were bathing/showering: The resident requires (Total dependence) by (1-2) staff with bathing/showering (3 times) and as necessary, bed mobility: the resident requires (extensive assistance) by (1-2) staff to turn and reposition in bed. Dressing: The resident requires (extensive assistance) by (1-2) staff to dress. Eating: The resident requires (Supervision) by (1) staff to eat . Personal Hygiene: The resident requires (Supervision) by (1) staff with personal hygiene and oral care. Toilet use: The resident requires (Extensive assistance) by (1-2) staff for toileting. Transfer: The resident requires (Extensive assistance) by (1-2) staff to move between surfaces. Focus: Limited physical mobility route of decrease in functional mobility, obesity, lymphedema, weakness with interventions being locomotion: The resident requires (Extensive assistance) by (1) staff for locomotion using (wheelchair). Observation and interview on 6/28/22 at 11:35 a.m. with Resident #5 she was observed lying in bed and it was warm in the room and there was an odor of feces. Resident was observed to be obese, and she said things have not been good at the facility lately. Observation revealed an odor in the room. She said they don't give her deodorant or the basics, they have to buy their own. The doctor said she had to use name brand soaps and lotion, and the unscented soaps Resident #5 said she has not been cleaned up yet. Her bath aides normally come after lunch time. She said MWF are her bath days, but she is a big girl and needs to bathe daily. Her briefs have not been changed today. She said CNA, changed her today at 2:30 a.m. and that was the last time anyone had changed her. Resident #5 said she had requested in the past to get baths daily, but they said they only bathe the 3 days. They give her bed baths when they bathe her. She asked them to take her to the shower, but they have to use the Hoyer lift. They said that for her it was too much for them to take her to the shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident #5 and ADON on 6/28/22 at 12:11 p.m., ADON said residents are changed every 2 hrs. Resident #5 answered the ADON saying she was not changed every 2 hrs. and ADON did check Resident #5's brief and observation with ADON revealed a bubble of fluid on the resident's side on leg that was leaking. The ADON said Resident #5 brief was soaked with urine and feces. ADON asked Resident #5 if she called anyone to change her and she said yes, and that CNA D was her aide. She had the light on, and one of the nurses answered and said CNA D was her nurse. The ADON said when the aide comes on shift, they are supposed to come to introduce herself to the resident. The Nurse turned the light off. Observation revealed ADON checked Resident #5's briefs at this time and said the resident did have a bowel movement. It is not the resident's responsibility to call for the staff they should come every 2 hours. She wanted to know who answered the light and who she called to answer the light to help the resident. The ADON said Resident #5 preferred bed baths. Resident #5 said no she never said that, and that she was told they did not have anyone to take her to the shower. The ADON said she has to follow up to see if they can get the equipment to take her to the shower. Resident #5 said a former CNA took her to the shower. Resident said she has all the equipment she needs to be able to get the shower. The ADON said Resident #5 has to work with therapy to train on how to transfer from the bed to the shower and bring her back. Safety first. She had a shower last year. She has been getting bed baths. She had a bed bath yesterday. Interview on 6/28/22 at 1:21 p.m. with CNA D she said she came in at 6 a.m. and she leaves 6 p.m. CNA D said she knocked on Resident #5's door this morning and said this is CNA D and let her know she would be the CNA today and she went to pass the trays. It was supposed to be 3 CNA's, but they found out it was only 2 staff. CNA D said the CNA's started changing residents and halfway through breakfast they feed people. Her call light was on, and the nurse went in and saw the light and said Resident #5 did not need anything. She said the nurse said Resident #5 said she did not need to be changed yet. The first shift left at 6 a.m. They are supposed to go every 2 hours. She went in to check on the resident before lunch and she said she was ok. She says she did not check the time. It was between 10 and 11 a.m. Resident did not have that bowel movement before when she went in to check the resident. The residents have a right to ask for a bath whenever they want, and they have to give it to them. CNA D said this was her 3rd week working at the facility. CNA D said she does not mind giving the resident a shower, but they need a secure shower bed or chair for her. She said she cannot just get Resident #5 up; they need to make sure it is solid enough to support her weight. CNA D said Resident #5 loves her bath. Observation and interview on 7/6/22 at 12:40 p.m. with CNA E came to give Resident #5 her bed bath. CNA E said Resident #5 always says she wants to take a bath or go to the shower. CNA E said the nurses say they don't have a good enough Hoyer pad for her, so they just give her a bed bath. Interview on 7/6/22 at 3:41 p.m. never refused therapy at any time. She cooperated with PT. The resident did make progress. Made bed mobility activities. Sitting at edge of bed sit to stand as much as tolerated. She can only bear wait for short times. She has a boot that was modified for her. Once a week to stand and twice a week sit at edge of bed. She is not able to come out of her room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/6/22 at 3:50 p.m. with Director of Physical Therapy (PT) she said the first Resident #5 was seen was on 1/20/21 and ended on 2/9/21. During this time, Resident #5 had not gotten out the bed, but they got Resident #5 custom braces. She said from 4/25/22 to 5/25/22 was the last time Physical Therapy and she discharged with her bed mobility was at minimum assistance and she was able to move to sitting at the edge of bed with Moderate assistance. Resident #5's dynamic sitting was standing by assistance to contact guard assistance standing beside her to make sure she does not lose her balance. She said Resident #5 worked on standing with a walker and 2 people assisting her. She said Physical Therapy saw Resident #5, 7 times, and she has always been cooperative. Physical Therapy did not do showers with Resident #5 because Nursing does the showers. She said they would not have an objection to Resident #5 getting a shower and she is capable of washing her upper body by herself. Resident #6 Record review of Resident #6's face sheet revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] whose diagnosis included chronic respiratory with hypoxia (severe pneumonia with problems with breathing), critical illness myopathy (disease of limb and respiratory disease), atrial fibrillation (irregular fast heart beat), tracheostomy (whole in windpipe to help with breathing), diabetes mellitus (blood sugar), hypomagnesemia (electrolyte disturbance due to low level of serum magnesium), and morbid (severe) obesity with alveolar hypoventilation (person does not take enough breaths per minute). Record review of Resident #6's MDS dated [DATE] revealed a BIMS Summary score of 15 (cognitively intact). Walking in room and corridor did not occur, she was totally dependent with two staff assisting for transferring, dressing, toilet use and personal hygiene, totally dependent with one staff assisting for locomotion on and off the unit, extensive assistance with two staff assisting with bed mobility and totally dependent with one staff for bathing. She weighed 630 lbs. Resident was not rated for urinary continence and she was always incontinent of bowel. Record review of Resident #6's Care Plan dated 6/2/22 indicated Resident #6 requested 2 briefs on at all times, interventions were to check frequently as required for incontinence; history of resisting/refusing care with incontinent care and weights at times, interventions were do not rush resident when providing care and educate resident on importance of letting staff provide/assist with care allowing staff to performing incontinent care ; ADL self-care deficit performance deficit r/t Activity Intolerance, Confusion, Impaired balance, Limited Mobility, lack of coordination, muscle wasting and atrophy, interventions were bathing/showering required (Total Dependence) by (1) staff (3x a week) and as necessary, bed mobility (Extensive assistance) by (1-2) staff to turn and reposition in bed, dressing (Extensive assistance) by (1-2), eating (Supervision) by (1) staff, personal hygiene and oral care (Extensive assistance) by (1-2) staff and oral care, toilet use (Total dependence) by (1-2) staff, transfer (Extensive assistance) by (1-2) staff, encourage the resident to participate to the fullest extent possible with each interaction; potential impairment to skin integrity r/t decreased mobility, incontinence, interventions were avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; bowel/ bladder incontinence r/t Activity Intolerance, Impaired Mobility encourage fluids during the day to promote prompted voiding responses, incontinent: Check frequently and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/6/22 at 2:40 p.m. with Resident #6 she said she wants to take a shower, but they don't have a chair big enough for her and they don't have a chair big enough to get her there. Her wheelchair just came in last week. They did not have anything to transport her. They give her bed baths. Resident #6 said she was told that she could not take a shower. Record review of facility's policy on Activities of Daily Living (ADLs) dated 1/1/22 revealed, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation, 3. Toileting . Record review of facility's policy on Care and Treatment of Bariatric Residents dated 1/1/22 revealed, Bariatric residents have special needs. This facility will provide the necessary care and treatment that allows the bariatric resident to remain safe and to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being .Facility still will identify equipment needs of the bariatric resident during the pre-screening and admission process. Equipment will be available upon admission for providing for the immediate needs of the resident . Considerations for equipment needs include, but are not limited to . Wheelchairs or other mobility aids, Resident lifts that can accommodate resident's size and weight, shower chairs or commodes .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 20 residents (Resident #2) reviewed for quality of care. -The NF failed to change Resident #2 PICC/central line dressing that was dated 06/11/2022 when the PICC/central lines are to be changed every seven days. This failure could place residents who had a central line at risk for infections, decrease in their quality of life, and quality of care. Findings include: Resident #2 Record review of Resident #2's face sheet revealed an she was a 61year old female admitted to the NF originally on 04/01/2022 and again on 04/22/2022 with the following diagnoses; acute respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), pressure ulcer of the right hip stage 4, pressure ulcer of other site stage 4, non-pressure ulcer chronic of left heel and midfoot, non-pressure ulcer of right foot, bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), elevated white blood cell count, tachycardia (fast heart rate), hypoxemia (an abnormally low concentration of oxygen in the blood), and fever. Record review of Resident #2's MDS dated [DATE] revealed Resident #2 had a BIMS score of 3 indicating his cognition was severely impaired. Further review revealed that resident was totally dependent in bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. Further review revealed that resident was occasionally incontinent of urine incontinent and always incontinent of bowel. Record review of Resident #2's care plan did not reveal that resident was being care planned for a PICC/central line. Record review of Resident #2's hospital records dated 04/21/2022 revealed that resident had a PICC line insertion on 04/19/2022 to the right upper arm. Record review of Resident #2's Physician orders summary report did not reveal an order to change dressing of Resident #2's PICC/central line. Further record review of Physician orders regarding resident PICC/central line dated 04/21/2022 revealed an order to use 10ml saline intravenously as needed for blood sampling direction: flush with 10ml, aspirate 5 ml of blood and waste it: draw sample then flush with 10-20ml normal saline, change end of cap. Observation on 06/30/2022 at 10:50am Resident #2 had a central line to her right upper arm with date on the dressing site read 06/11/2022. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/30/2022 at 11:00am LVN A said it was the Infection Control Nurse that done the central line dressing changes. Interview on 06/30/2022 at 11:20am LVN B said the central line dressing changes were to be changed every 3-7 days but was not sure. LVN B said PCC would alert the nurse when the central line dressing was due to be changed. LVN B said the reason the central line dressings needed to be changed often was to prevent infections. Interview on 06/30/2022 at 11:50am, the Infection Control Nurse, after observing the date on Resident #2's PICC/central line dressing said the date on Resident #2's PICC line dressing was 06/11/2022. The Infection Control Nurse said the reason Resident #2's PICC/central line dressing had not been change was due to the NF experiencing an outbreak of COVID-19 cases. The Infection Control Nurse said she became busy with notifying families, in-servicing, and educating the staff regarding the COVID-19. The Infection Control Nurse said she was not aware of who would assist with central line dressing changes if she was not at the NF. The Infection Control Nurse said she was not aware of Resident #2 not having any physician orders for the PICC/central Line dressing changes. The Infection Control Nurse said the central line/PICC line dressings were to be changed every 7 days or as needed for infection control purposes. The Infection Control Nurse said the NF had 3 residents with Central Lines. Interview on 06/30/2022 at 1:00pm the DON said it was the Infection Control Nurse that done all the central line dressing changes every seven days and as needed to prevent the site from getting infected. The DON said it was the Unit Manger and herself that would assist with central line dressing changes if the Infection Control Nurse was not at the facility. Record review of the NF policy on Intravenous Therapy revised 2021 revealed in part: .Midline and Central line IV sites will be changed at least every 7 days .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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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 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** 35822 Based on observation, interview, and record review it was determined the facility failed to ensure residents who were incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 20 residents reviewed for incontinent care (Resident #4) in that: -CNA C did not practice proper technique when providing Foley catheter care for Resident #4. This failure affected one resident who had an indwelling Foley catheter and history of urinary tract infection at risk for increase infections and hospitalization . Findings include: Resident #4 Record review of Resident #4's face sheet revealed a [AGE] year old male admitted to the NF originally on 09/07/2012 and again on 07/05/2022 with the following diagnoses; quadriplegia (paralysis of all four limbs), hypertension (high blood pressure), cerebral infarction (stroke), joint contracture (a permanent tightening of the muscles that cause the joints to shorten and become stiff), anxiety disorder, insomnia (difficulty sleeping), non-pressure chronic ulcer left thigh and lower left leg, sleep apnea (when breathing repeatedly stops and starts), muscle weakness, autonomic neuropathy (dysfunction of the nerves that regulates body functions such as the heart rate, blood pressure, and sweating), lymphedema (swelling in arm or leg), hemiplegia (paralysis of one side of the body), neuromuscular dysfunction of the bladder (lacking bladder control), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder), xerosis cutis (rough, dry skin that may have scales or small cracks), chronic embolism (obstruction of an artery) and thrombosis (blood clots), diabetes mellitus, bipolar disorder (episodes of mood swings), and atherosclerosis (disease of the artery due to fatty materials in the arteries). Record review of Resident #4's MDS dated [DATE] revealed a BIMS score of 13 indicating cognition level intact. Further review revealed that resident required extensive assistance with bed mobility, transfer, dressing, eating, and toilet use. Further review revealed that resident was occasionally incontinent of urine and frequently incontinent of bowel. Record review of Resident #4's hospital records revealed that resident was admitted to the hospital on 06/26/2022 admitting diagnosis was COVID, sepsis, and urinary tract infection. Further review revealed that resident WBC was 12.4 (norm: 4.5-11). Record review of Resident #4's care plan dated 05/05/2022 revealed that resident was being care planned for indwelling catheter with an intervention to monitor and report to the MD for signs and symptoms of urinary tract infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/06/2022 at 4:10pm of CNA C providing Foley catheter care for Resident #4 with the assistance of LVN D. During Foley catheter care the CNA C did not clean resident in circular motion moving downward away from the meatus (the opening of the penis where urine comes out). Instead, CNA C wiped back and forward. When cleaning resident Foley catheter tubing, CNA C did not clean one wipe at a time cleaning away from the meatus but cleaned back and forward. Further observation was made of CNA C not cleaning resident groin areas. Interview on 07/06/2022 at 4:20pm with CNA C said she did not feel like she provided good catheter care for Resident #4. CNA C said she forgot to clean resident groin area because she was nervous. CNA C said it was it was important to clean resident properly to prevent infections. CNA C said she had been working at the NF for 2 months and prior to working at the NF she worked at Assisted Living facilities periodically. CNA C said no one at the NF had done skills checked off with her regarding Foley catheter care. Interview on 07/06/2022 at 4:30pm with the DON regarding Foley catheter care said the NF did not have a skill's check list for incontinent care and the NF was in the process of developing one. The DON said it was the lead CNAs on the floor that oriented the new CNA's. Record review of the NF policy on Foley Catheter care for the male resident revised 2021 revealed in part: .It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care .gently grasp penis, draw foreskin back if applicable using a circular motion, cleanse the meatus with a clean cloth moisten with water and perineal cleaner (soap) .with a new moisten cloth, starting at the urinary meatus moving down, cleanse the shaft of the penis .dry area with towel

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheotomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, for 1 of 20 residents reviewed for tracheotomy care (Resident # 2) in that: -LVN A failed to use sterile technique during tracheotomy suctioning for Resident #2. This failure placed residents with tracheostomies requiring suctioning at risk for respiratory infections, hospitalization , and a decline in their quality of life. Findings Include: Record review of Resident #2's face sheet revealed an 61year old female admitted to the NF originally on 04/01/2022 and again on 04/22/2022 with the following diagnoses; acute respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), pressure ulcer of the right hip stage 4, pressure ulcer of other site stage 4, non-pressure ulcer chronic of left heel and midfoot, non-pressure ulcer of right foot, bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), elevated white blood cell count, tachycardia (fast heart rate), hypoxemia (an abnormally low concentration of oxygen in the blood), and fever. Record review of Resident #2's MDS dated [DATE] revealed Resident #2 had a BIMS score of 3 indicating her cognition was severely impaired, and was totally dependent in bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. Further review revealed she was occasionally incontinent of urine incontinent and always incontinent of bowel. Record review of Resident #2's care plan dated 07/26/2022 revealed she was being care planned for a tracheostomy care. Record review of Resident #2's Physician's order dated 05/02/2022 revealed an order for tracheostomy suctioning BID and PRN as needed. Observation on 06/30/2022 at 10:50am revealed Resident #2 was resting on a low bed with an air mattress receiving continuous gastrostomy feedings of Jevity at 55 ml/hr along with a continuous water flush at 30ml/hr hung on 06/30/2022. The resident's head of bed was elevated. Resident had a tracheostomy connected to oxygen with no distress observed. Resident #2 was resting on her left side with clear mucus secretions coming from underneath her trach dressing site on the chest area. Resident #2's trach dressing was clean. Resident sounded like she needed to suction due to a gurgling sound that was heard coming from trach area. LVN A had entered the room and said she had been in-service on trach care and suctioning by the RT. LVN A said she could perform suction care on Resident #2. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/30/22 at 11:05am of trach suctioning was provided for Resident #2 by LVN A. LVN A washed her hands, placed on clean gloves, and began to open the sterile suction kit that was at resident bedside. After opening kit, LVN A washed hands again and placed on sterile gloves and proceeded to suction resident by using her sterile right gloved hand to turn on suction machine. After doing this, LVN A continued to use her right hand to suction Resident #2. In an interview on 06/30/2022 at 11:15am LVN A said it was important to establish which hand was going to be the dominant hand when suctioning a tracheostomy to prevent breaking sterile field and introducing bacteria inside of the resident's trach. LVN A said she was not aware that she had used the same hand to turn on the suction machine and suction Resident #2's tracheostomy. Interview on 07/06/2022 at 3:20m the Director of Respiratory Therapy said Human Resources kept the Nursing staff training regarding respiratory, tracheostomy, and suctioning care. The Director of Respiratory said he trained the nurses on tracheostomy care and suctioning utilizing a checklist regarding tracheotomy care. The Director of Respiratory said if a nurse appeared apprehensive about tracheostomy care he would continue to work with that nurse. The Director of Respiratory said during training, he had the nurses to do return demonstration as well as verbalization of understanding regarding tracheotomy care to ensure the nurses could perform tracheotomy suctioning correctly. The Director of Respiratory said according to the NF policy and procedures, tracheotomy suctioning was a sterile procedure to prevent infections. Record review of the NF policy on Suctioning: Tracheostomy or Endotracheal revised 01/2021 revealed in part: .Suctioning of the tracheostomy or endotracheal tube is performed using sterile technique to remove secretions from the tracheobronchial tree using sterile technique .put on sterile gloves; one hand will serve as the sterile hand to guide the catheter and the other hand will serve as the contaminated hand .With sterile hand remove suction catheter from package and curl catheter around gloved fingers .with contaminated hand, connect suction catheter to suction source .

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32677 Based on observation, interviews, and record reviews the facility failed the ensure a physician reviewed the resident's total program of care at each visit for 1 of 20 residents (Resident #5) whose physician services were reviewed in that: -The facility physician did not treat or monitor Resident #5's chronic lymphedema since admission on [DATE] through [DATE] This failure could place residents at risk for prompt intervention in her care leading to a decline in health status and untreated conditions. Findings included: Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] whose diagnosis included hypertensive heart disease with heart failure (high blood pressure), hypothyroidism (thyroid gland does not produce enough hormones), morbid obesity due to excess calories, lymphedema (tissue swelling caused by protein rich fluid), muscle weakness, chronic pain syndrome, and problem related to care provider dependency. Record review of Resident #5's MDS dated [DATE] revealed a BIMS Summary score of 15 (cognitively intact); She did not have any behaviors, required extensive assistance with two person assist for bed mobility, transfer; walking in room, corridor and locomotion off unit did not occur; locomotion on unit occurred once or twice with two person assist; extensive assist with one person physical assist with dressing, toilet use and personal hygiene; and she was totally dependent on staff with two person assist with bathing. She was frequently incontinent of urine and bowel, and resident weight was 566 lbs. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's Care Plan dated [DATE] indicated Resident #5 had shortness of breath, edema, fatigue and weakness with interventions of notify Medical Doctor and responsible party of change in condition, observe for edema, provide medications as ordered, provide O2 and NEB treatments as ordered and indicated. She was incontinent of bowel/bladder, interventions were to check the resident as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes; Risk for skin breakdown route of decreased mobility, incontinence, lymphedema with interventions as encourage resident and provide assistance to turn and reposition every 2 hours and PRN comfort and follow facility policies/protocols for the prevention/treatment of skin breakdown, notify MD and Responsible party of change in condition, observe skin weekly per schedule and any reports of open/red area. Notify MD and wound care nurse as appropriate and implement ordered interventions, observe skin when providing care for redness, open area and notify Nurse, provide assistance for toileting/incontinence checks every 2 hours and PRN. Provide peri-care, buttocks are post incontinent episode per facility policy, provide shower/bed bath per schedule and PRN .; She has an ADL self-care performance deficit route of Activity intolerance, impaired balance, limited mobility, pain and interventions were bathing/showering: The resident requires (Total dependence) by (,d+[DATE]) staff with bathing/showering (3 times) and as necessary, bed mobility: the resident requires (extensive assistance) by (,d+[DATE]) staff to turn and reposition in bed. Dressing: The resident requires (extensive assistance) by (,d+[DATE]) staff to dress. Eating: The resident requires (Supervision) by (1) staff to eat . Personal Hygiene: The resident requires (Supervision) by (1) staff with personal hygiene and oral care. Toilet use: The resident requires (Extensive assistance) by (,d+[DATE]) staff for toileting. Transfer: The resident requires (Extensive assistance) by (,d+[DATE]) staff to move between surfaces. Focus: Limited physical mobility route of decrease in functional mobility, obesity, lymphedema, weakness with interventions being locomotion: The resident requires (Extensive assistance) by (1) staff for locomotion using (wheelchair). Record review of Resident #5's physician orders revealed, vascular consult for lymphedema management active [DATE]. Record reviews of Resident #5's physician orders did not reveal any orders before [DATE] for lymphedema management. Record review of Resident #5's progress notes from [DATE] to [DATE] did not reveal any further notes regarding Resident #5 receiving assistance with lymphedema treatment. Record review of Resident #5's Progress Notes dated [DATE] at 11:27 a.m. by LVN E revealed, Writer spoke with diabetes Institute on call regarding resident's request for referral/approval to see lymphedema specialist, Diabetes Institute stated she will notify Facility Doctor and will set up appointment and that she will also notify social worker. Social worker notified and stated he will follow up with resident's request and arrange transportation as needed. Resident notified. Record review of Resident #5's Progress notes dated [DATE] at 9:20 a.m. by ADON revealed, At 9 a.m. made round, resident was in bed, no complain, no distress, breathing even. Resident said to the writer that Doctor office called her yesterday at 4 p.m. and told her she was approved for the lymphedema treatment and expecting appointment call today. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on [DATE] at 11:35 a.m. with Resident #5 she said the facility Doctor almost killed her in November last year in 2021. Resident #5 said she was sent to the facility from Florida, and she had been at the facility since [DATE], and the fluid started coming out of her leg. She said in [DATE] she almost died with the fluid on her chest. Resident #5 said she was supposed to have lymphatic treatment, but since [DATE], the fluids popped out of her leg, and the doctor denied her care. She said she was sent here from Florida to be treated for lymphedema. Resident #5 said she called her insurance company and the places the facility was trying to send her were not in their network. In a continued observation and interview on [DATE] at 12 p.m. with Resident #5 and ADON, Resident #5 said she had been at the facility since [DATE] and had not received Lymph treatment yet. Resident #5 said in the beginning, she did not know that she could change doctors because the facility doctor refused to treat her. She said she does not refuse care and that she was using a breathing machine to strengthen her breaths. Observation with ADON revealed a bubble of fluid on the resident's side of her leg that was leaking. The ADON said it was lymphedema. The ADON said she has been working at the facility for 3 months. Interview and record review on [DATE] at 12:37 p.m. with ADON she revealed that she received a text message at this time saying resident had an appointment with Lymphedema Therapy Specialist on Wednesday 29, 2022 at 9 a.m. that Resident #5 found the doctor herself through her insurance company and the ADON began communicating with them. Interview on [DATE] at 10:34 a.m. with ADON she said she called the doctor's office at around 3 p.m. yesterday to find out if she comes on wheelchair or a bed and they said they did not need the resident to come. The Doctors office and the insurance company will discuss the resident's care. She said on yesterday, [DATE] the Lymphedema Doctor's office called and denied the resident, but this morning they called her again and she has another appointment, and she was approved for treatment with another doctor in their office who takes her insurance. Resident #5's Doctor appointment is set for [DATE] at 3 p.m. The ADON said she has already scheduled the pickup for 2 p.m. via stretcher. The SW is the one who is responsible to coordinate with insurance. The resident is really involved in her care. Interview on [DATE] at 10:45 a.m. with Resident #5 she said on Tuesday, [DATE] the appointment was scheduled, but it was for the doctor to discuss her case. She said she had not been approved yet. Resident #5 said this morning she got the appointment, and she will go on Monday, Wednesday and Friday and they will wrap her legs and take care of her legs. Resident #5 said they gave her approval for 20 sessions. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review and Interview on [DATE] at 11:27 a.m. with Social Worker (SW) she said she had been working at the facility since Feb. 2022. The Social Worker said when she started Resident #5 had to be seen by the Lymphedema Dr and she made an appointment, but it was cancelled because she did not select the write lymphedema facility that would be approved by Resident #5's insurance. She looked on her insurance to see if the center took her insurance and then they no longer took the insurance. SW checked the facility progress notes and said in March Resident #5 had an initial appointment on [DATE] and Resident #5 went to the appointment and went to another, and it got cancelled with insurance. Then the facility scheduled to go to another, but at that point she wanted them to cancel the appointment and she would work with her insurance. The Social Worker said before she came to work at the facility, there was no documentation from the previous SW regarding the lymphedema treatment and there are no notes from the facility Doctor saying anything about treating for lymphedema. Interview on [DATE] at 12:27 p.m. with Resident #5 she said the incident happened in [DATE] that she had fluid building up in her chest. Resident #5 said she was going today at 3 p.m. to the Lymphedema center. Resident #5 said she told the facility doctor about her condition, and he looked at her weight and said she needed to move around to lose the weight. Resident #5 said the facility Doctor did not do anything until he saw the fluid coming out of her legs. When she went into the hospital in November and came back in December. She had 3 referrals to be denied. She said she had never told the facility that she did not want their help in scheduling for the lymphedema center. She said the facility lied. She says she cannot do it herself. She never said she was going to do it on her own and she need help. Resident #5 said the facility and the Physician was not doing anything, so she got on the phone with her insurance company. She called and she found one and just got the approval. Interview on [DATE] at 1:11p.m. with Social worker she said Resident #5's initial appointment was on [DATE] and then there was another appointment, but the Resident did not want to go to. The Social worker could not find any doctor notes in the system. The facility does not have any paper Doctors notes. Interview on [DATE] at 1:50 p.m. with Administrator he said the facility did not have any of the Doctor's notes from any of his visits with Resident #5. The Administrator said he would request the notes from the Doctor. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone Interview on [DATE] at 2:07 p.m. with Facility Doctor he said Resident #5 said she wanted another Doctor. He said he met Resident #5 at the hospital, and she did rehab. The facility Doctor said Resident #5 is morbidly obese, humongous, she is fat, and she had 2 weeks of rehab. The facility Doctor said Resident #5 said she had a fluid problem, but she had a weight loss problem. He is in the process of ordering the records. In October towards the end of [DATE] he told her she needed to get out of the bed. Resident #5 said it was the lymphedema in [DATE] when she wanted to go to the hospital. The facility Doctor said it was his fault that it took so long to get the treatment for lymphedema. He said he could not find anyone who took her insurance. They finally found someone who took Medicaid and when they tried to put her on the stretcher she refused. The resident did fit the stretcher, but she was not comfortable, so she refused to go to the appointment. The next month she called saying she did not want to see him. Resident cannot do anything and was totally dependent. In his opinion, the lymphedema is not even the issue. It is the morbid obesity and loss of function and loss of strength. The insurance paid for 2 weeks of rehab. He told the resident she needs to start moving. He said let him find someone who did the lymphedema. He is guilty for her not receiving treatment because it took them forever to find a place that took Medicaid. There is no reason not to have an evaluation for lymphedema. This is morbid obesity in the abdomen and the chest. The major problem was the loss of function. Interview on [DATE] at 4:24 p.m. with the Business Office Manager she said in Resident #5's records she can only go back to [DATE]. She said in her time period nothing ended for her and her services were continuous. Record review of Facility's policy on, Provision of Physician Ordered Services, dated [DATE] revealed, The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality .Professional Standards of Quality means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Record review of Facility's policy on, Provision of Quality Care, dated [DATE] revealed, Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices .Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.