STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675638	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines Nursing and Rehabilitation	3301 E. Mockingbird Lane Victoria, TX 77904

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

(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 - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on Observations, Interviews, and Record review, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 out of 3 (Resident #5) reviewed for call light. The facility failed to ensure Resident #5's call light was within reach. This failure could place residents at risk of achieving independent functioning, dignity, and well-being. Findings included: Record review of Resident #5's face sheet dated 12/3/24 revealed [AGE] year old female admitted to the facility on [DATE]. Resident #5 had diagnosis that included Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform daily tasks), Insomnia (sleep disorder that makes it difficult to fall asleep, stay asleep, or get quality sleep), and Seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements). Record review of Residents #5's Quarterly MDS, dated [DATE], reflected a BIMS score left blank which suggested Resident #5 was unable to complete the interview. Record review of Resident's #5's care plan, dated 7/18/24, revealed a focus was the resident was at risk for falls, intervention was to, be sure call light is within reach. Observation on 12/03/24 in Resident #5's room at 9:40 AM revealed that the call light was found on the night stand out of reach. In an Interview with NA A on 12/3/24 at 10:00 AM she stated she was the assigned NA A for Resident #5, she confirmed the call light was on the night stand out of reach, she added that she must of placed call light in the night stand earlier this morning when she was providing care to Resident #5 and had forgotten to place it at arms reach. NA A added that the call light should always be at arm's reach for any resident just in case they needed assistance. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RCN on 12/03/24, at 11:45 AM, the RCN stated the facility did not have a policy that addressed call lights but emphasized the importance of ensuring that the call light was accessible to all residents, she stated the lack of accessibility to a call light for any resident could lead to a fall if assistance was needed. The RCN also mentioned that charge nurses currently monitor this task during their rounds daily, and her leadership team were responsible for overseeing this process during morning rounds.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observations, interviews, and record reviews, the facility failed to ensure residents have a right to personal privacy for 2 of 2 residents (Residents #70 and #78) reviewed for privacy, in that: 1. MA M did not close the computer screen exposing Resident #70's personal medical information. 2. LVN K and LVN L did not completely close Resident #78's privacy curtain while providing wound care. This failure could place residents at-risk of loss of dignity due to lack of privacy. The findings included: 1. Record review of Resident #70's face sheet dated, 12/4/24, revealed a [AGE] year old female with an admitted [DATE], with diagnoses that included: Dementia (is the loss of cognitive functioning thinking, remembering, and reasoning), Bipolar disorder (mental health conditions characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function), and Major Depression Disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #70's quarterly MDS assessment dated [DATE], revealed a BIMS score of 15 which indicated an intact cognition. Observation and Interview on 12/4/24 at 12:15 PM revealed MA M administering medications to Resident #70 in the dining room and stepping away from the computer without locking the screen. MA A stated she was near the computer, and she did not need to lock the screen. She stated by stepping away from the computer and not locking the screen, Resident #70's information may have been exposed. In an Interview with the RCN on 12/4/24 at 2:12 PM she stated MA M should have closed the screen when she stepped away from computer, which risked Resident's #70's medical information being exposed. She stated it was her expectation that all nursing staff closed the screen when away from the computer, she added the DON would be responsible for over seeing this and the ADON would be monitoring this at random to ensure compliance. 2. Record review of Resident #78's face sheet, dated 12/04/2024, reflected an [AGE] year old female with an initial admitted [DATE] and re-admission on 07/20/2023, with diagnoses which included: Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions); Type 2 Diabetes Mellitus (chronic condition resulting in persistently high blood sugar levels) and pressure ulcer of sacral region stage 4 (full thickness tissue loss with exposed bone, or muscle located near tailbone). Record review of Resident #78's Quarterly MDS assessment, dated 11/05/2024, revealed a BIMS score of 3, indicating severe cognitive impairment and required partial/moderate assistance, in toileting hygiene. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #78's Care Plan initiated 3/8/2023 revealed a focus area for Stage 4 left gluteal pressure wound revised on 11/27/2024, with interventions that included: Cleanse with NS [normal saline], Pat dry with 4x4 gauze. Apply Isosorb [medicated gel to treat wounds] and Collagen [helps with skin regeneration] to wound bed. Cover with silicone dressing. Daily. Observation on 12/04/2024 at 11:55 a.m., reflected LVN K and LVN L attempted, but were not able to completely close the privacy curtains around Resident #78's bed, as the privacy curtain jammed and would not completely extend the distance needed to block visual view completely around the bed. This left a 2- foot opening between the curtains near the foot of the bed while they provided wound care for Resident #78, during which the resident's buttocks were exposed and could be seen by anyone entering the room. During an interview with LVN K and LVN L on 12/04/2024 at 12:33 p.m. they verbally confirmed the privacy curtains were not completely closed while they provided wound care for Resident #78, because they could not physically close the curtain. They also stated they knew it was important to close the curtains all the way to provide privacy to the resident. They stated it was housekeeping's responsibility to maintain the privacy curtains in the resident's rooms. During an interview with the RCN on 12/04//2024 at 1:55 pm, the RCN stated privacy must be provided with closed privacy curtains for any patient care activity including wound care and peri-care to protect their dignity, and that she would make sure the privacy curtains in resident rooms were fixed so that they closed completely. During an interview with the Housekeeping Supervisor on 12/06/2026 at 12:33 p.m., the Housekeeping Supervisor stated that housekeeping was responsible for cleaning and maintaining the privacy curtains in resident's rooms and that they have had problems with missing hooks, or worn-out wheel bearings, resulting in jams preventing the privacy curtains from closing all the way. She stated she has in-serviced the housekeeping staff to test the curtains after hanging them up to ensure they close completely to provide 100% privacy to the residents. She stated the housekeepers should make a request to the maintenance department when curtains jam and don't close properly with a copy to her so she could follow up on the work. However, after a brief search of her email, the Housekeeping Supervisor was unable to provide any copies of requests to maintenance to fix the broken privacy curtains, which may have resulted in privacy curtains not being fixed when broken. Review of the facility's policy titled Resident Rights Policy, undated, reflected, The resident has a right to personal privacy and confidentiality of his or her personal and medical records and 1. Personal privacy includes accommodations, medical treatment, written and telephone communication, personal care, visits and meetings of family and resident groups 46131

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on observation, interview, and record review, the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment for 1 (Resident #77's room) of 80 resident rooms reviewed, in that: A foul odor was emanating from the restroom of Resident #77's room. This failure could result in psychosocial harm due to diminished quality of life. The findings were: Record review of Resident #77's face sheet, dated 12/06/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Type 2 Diabetes Mellitus, Hyperlipidemia, and Anemia. Record review of Resident #77's Quarterly MDS, dated [DATE], revealed a BIMS score of 09 which indicated moderate cognitive impairment. Record review of Resident #77's care plan, initiated 08/24/2024, revealed [Resident #77] to remain in facility for long term care, with a goal, [Resident #77's] needs will be met during this review period. Observation on 12/03/2024 at 10:40 a.m. revealed the presence of a foul odor emanating from the restroom of Resident #77's room with no apparent source of the odor. The floor, toilet, trash can, and sink appeared clean. During an interview with Resident #77 on 12/03/2024 at 10:40 a.m., Resident #77 stated that the odor had been present for a few days and was bothersome. During an interview with NA A on 12/03/2024 at 10:42 a.m., NA A confirmed that a foul odor was emanating from the restroom of Resident #77's room, and confirmed there was no apparent source of the odor. During an interview with the Administrator on 12/06/2024 at 11:45 a.m., the Administrator stated that the facility had had issues with drains and that may have caused the foul odor. During an interview with the Housekeeping Supervisor on 12/06/2024 at 12:40 p.m., the Housekeeping Supervisor stated that a foul odor had been present in the past next door to Resident #77's room and that her staff solved the issue by treating the drains. She confirmed that she had been notified of the odor in Resident #77's room and stated that her staff had treated the drain and the odor dissipated. During an interview with Resident #77 on 12/06/2024 at 10:12 p.m., Resident #77 confirmed the odor in his room was gone. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, Resident Rights, undated, revealed, The resident has a right to a safe, clean, comfortable and homelike environment. The facility must provide .housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to develop a baseline care plan including the minimum healthcare information necessary to properly care for the resident within 48 hours of the resident's admission, for 1 (Resident #259) of 28 residents reviewed, in that: Resident #259's baseline care plan did not include his allergies or his physician-prescribed diet. This failure could result in improper care. The findings were: Record review of Resident #259's face sheet, dated 12/05/2024, revealed he was admitted to the facility on [DATE] with diagnoses including: Chronic Obstructive Pulmonary Disease, Hyperlipidemia, and Chronic Kidney Disease. Record review of Resident #259's clinical record as of 12/05/2024, revealed the resident was allergic to the medications Atorvastatin, Flomax, and Tramadol. Further review revealed the resident's physician ordered a regular diet with regular texture and regular consistency on 11/26/2024. Record review of Resident #259's baseline care plan, dated 11/26/2024, revealed the document included neither his allergies to medications nor his physician-prescribed diet. During an interview with RN/MDS B on 12/06/2024 at 10:32 a.m., RN/MDS B confirmed that Resident #259's baseline care plan did not include his allergies or his physician-prescribed diet and should have included both items. RN/MDS B further stated that the development of baseline care plans was the responsibility of the DON who had recently resigned and that the oversight should have been noted by the admitting nurse or one of the facility ADONs. Record review of the facility policy, Baseline Care Plans, undated, revealed, Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events .The baseline care plan will be developed within 48 hours of a resident's admission, include the minimum healthcare information necessary to properly care for a resident including, but not limited to - physician orders, dietary orders .interim approaches for meeting a resident's needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observations, interviews, and record review, the facility failed to review and revise Resident Care Plans after each assessment for 1 of 8 residents (Resident #42) reviewed for care plan revision and timing. The facility failed to ensure Resident #42's care plan was revised to reflect interventions made after an actual fall with injury on 09/06/2024. This failure could affect all residents and contribute to residents not receiving the care and services they needed to prevent falls. Findings included: Review of Resident #42's face sheet dated 12/06/2024, revealed she was an [AGE] year-old woman who had an initial admitted [DATE], with a re-admission on 09/10/2024 and diagnoses which included: Encephalopathy (damage or disease that affects brain function causing memory loss and confusion), Orthostatic Hypotension (a form of low blood pressure that happens when standing after sitting or lying down which can cause dizziness or feeling faint), unsteadiness on feet, lack of coordination and generalized muscle weakness. Record review of Resident #42's Significant Change MDS (modified) 5-day assessment dated [DATE] revealed she had a BIMS score of 2, indicating severe cognitive impairment, and indicated that there had been no falls since last assessment. Further review revealed Resident #42 was assessed as needing substantial to maximal assistance (helper does more than half the effort) for transfers, hygiene and wheeling self in wheelchair 150 feet. Observation and interview with Resident #42 on 12/03/2024 at 3:11 p.m. revealed she had a large gash with surrounding reddened area on her left forehead. Resident #42 stated she fell the previous night while leaning over in her wheelchair to pick up something off the floor and denied any current pain. Resident #42 was unable to recall if she has had any other falls. Review of the facility's Incident log and Event History for Resident #42 revealed that she has had 4 falls since her admission on 1/12/2024. These falls occurred on 01/13/2024, 03/11/2024, 09/06/2024 and 12/02/2024. Record review of Nursing Progress Note for Resident #42, dated 09/06/2024 at 06:28 a.m. by LVN J, read: Resident found by CNA on floor face down by her bed a pool of blood noted under her head instructed CNA to not move resident, 911 called . Record review of a Radiologic report from Hospital -O dated 09/06/2024 revealed findings of left frontal scalp swelling/laceration. and Impression: no acute intracranial process identified; atrophy and evidence of chronic microvascular ischemic changes. Further review of hospital records revealed she received 4 sutures to close her laceration and was also treated for other conditions including a urinary tract infection and anemia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #42's Nursing Note dated 12/02/2024 at 20:15 (10:15 p.m.) by LVN N, found under Incident Report section, revealed: Resident was calling for help and this nurse and came to see is she ok. Resident lying face down on the floor and blood to the floor. Resident fell out of her wheelchair as she was reaching to get something off the floor. This nurse initiated call to 911 Record review of Resident #42's Discharge Report dated 12/02/2024 from Hospital -O Emergency Department, revealed CT scans (computed tomography scan, an imaging technique used to obtain internal images of the body} of her Head and Cervical Spine were done, with findings of: Single superficial laceration to the forehead, Concussion with no loss of consciousness and acute cervical strain. Wound repair done and antibiotic was prescribed with discharge back to facility. Record Review of Resident #42's Care Plan last reviewed 11/29/2024, revealed a focus area for risk for falls r/t decreased mobility skills. Resident with noted falls on 1/13/2024 and 3/11/2024 with no injuries noted. This focus area had an initiation date of 1/16/2024 and a revision date of 7/11/2024. Review of interventions for this focus area revealed there were 12 interventions listed, all with an initiation date of 1/16/2024 with 3 of these interventions having a revision date of 1/28/2024. Review of interventions for this focus area revealed there were 12 interventions listed which included: - Anticipate and meet the resident's needs (initiated 1/16/2024); - Be sure the resident' s call light is within reach for assistance as needed (1/16/2024); - Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs (1/16/2024): - Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility (revised 1/28/2024); - Ensure resident is wearing appropriate footwear when ambulating or mobilizing in w/c (revised 1/28/2024); - Keep furniture in locked position (1/16//2024); - Keep needed items, water, etc . in reach (1/16/2024); - PT evaluate and treat as ordered or PRN (1/16/2024); - Review information on past falls and attempt to determine cause of falls. Alter remove any potential causes if possible. (1/16/2024); - Staff x1 to assist with transfers, - The Resident needs a safe environment with even floors free from spills and /or clutter, adequate glare-free light, working and reachable call light, bed in low position, handrails on walls and personal items within reach. (1/16/2024); (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident needs activities that minimize the potential for falls while providing diversion and distraction. (1/16/2024). This review shows there were no interventions or revisions to the focus area of falls on her Care Plan after her falls with injuries on 9/6/2024 and 12/02/2024. During an interview with RN/MDS B on 12/05/2024 at 8:55 a.m., RN/MDS B stated that Care Plan reviews were done for Resident #42 on 09/22/2024 and 11/29/2024 but confirmed the team did not revise or address any interventions under the focus area of falls after Resident #42's fall on 09/06/2024. Further interview with RN/MDS B revealed she was responsible for reviewing and updating the MDS and Care Plans quarterly and that the DON was responsible for updating the care plan for acute changes such as falls. She stated that the DON resigned last week, so now that responsibility would fall to the ADON. She stated resident falls were reviewed daily by the management team and causes/interventions discussed and that the resident's care plan should be updated after each fall with those interventions agreed to by team to ensure staff have the information needed to help prevent future falls. Interview with the ADON on 12/05/2024 at 9:30 a.m. revealed that the procedure for falls was that the management team met twice a day in the morning and afternoon to review significant events and status changes, including falls. Causes, and interventions for the falls would be discussed and it was the DON who was responsible for updating the care plan following acute medical changes and falls. She stated the DON left last week but had been here in September when Resident #42 had her fall on 09/06/2024. The ADON confirmed there were no revisions or interventions added to Resident #42's Care Plan since 7/11/2024 and stated that the Care Plan should have been revised and interventions updated after her fall on 09/06/2024. During interview with the RCN on 12/05/2024 at 10:15 a.m. the RCN noted that the falls on 01/13/2024 and 03/11/2024 were addressed in Resident #42's Care Plan, and provided and reviewed with the Health Surveyor the facility investigation report for the fall Resident #42 had on 09/6/2024 and stated that the fall was reviewed by the team and an intervention of physical therapy evaluation/treat was put in place, but the intervention was only noted on the investigation report. RCN confirmed that none of the interventions noted on the investigation report for the fall were added to Resident #42's Care Plan. She stated that the Care Plan for the focus area of falls had not been updated or revised after Resident #42's fall on 09/06/2024 or after her MDS significant change assessment was done on 09/12/2024 but should have been. The RCN stated they were in the process of reviewing Resident #42's fall on 12/02/2024 and updating her Care plan. She stated Care Plans needed to be kept updated so that staff had access to the most current information on how to care for each resident. Record review of the facility's policy titled Comprehensive Care Planning (undated) revealed The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 27923 Based on observations, interviews, and record review the facility failed to ensure a resident environment that remained as free of accident hazards as possible for one (Hallway A shower room) of four shower rooms observed for hazard free environment. The facility failed to ensure that the shower room on Hallway A remained a hazard free environment. This failure could place residents at risk encountering an accident hazard in the facility. Findings included: Observation on 12/3/24 at 11:50 am with AIT C and LVN E of the unlocked resident shower room on the A-hall revealed one 32 ounce bottle of K-Quat cleaning disinfectant placed on top of a standing tile ledge and second 32 ounce bottle of the same cleaning disinfectant placed inside of an unlocked standing shower cabinet. During an interview with the AIT C and LVN E on 12/3/24 at 11:55am they stated that the unsecured bottles of disinfectant could present a risk hazard to a resident who could enter the unlocked shower room and access the cleaning disinfectant for consumption. During an interview on 12/4/24 at 7:50 a.m. the Housekeeping Supervisor stated that she provided the cleaning disinfectant to nursing staff for use in the resident shower room. She stated that the cleaning disinfectant had to be secured in a locked cabinet after use and she had removed the disinfectant from the shower room. The Housekeeping Supervisor stated that resident access to the cleaning disinfectant would create a risk hazard to a resident who could consume the product. Record review of the facility's admission packet dated revised on 4/14/22 stated residents have the right to live in a safe, decent, and clean environment.

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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** 33866 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 3 the residents (Resident # 18) reviewed for oxygen use. The facility failed to ensure Residents #18's, oxygen tubing and mask was bagged and stored off the floor. This failure could place residents who received oxygen therapy at risk for an increase in respiratory complications. The findings were: Record review of Resident #18's face sheet dated 12/03/2024 revealed a [AGE] year-old male admitted to the facility initially on 12/12/2019 and readmitted on [DATE], and with diagnoses that included: Dementia (a group of symptoms affecting memory, thinking and social abilities) and Chronic Obstructive Pulmonary Disease (lung disease that blocks air flow and makes it difficult to breathe). Record review of Resident #18's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Record review of Resident #18's Physician Order Summary dated 12/03/2024 revealed an order for O2 [oxygen] at nasal cannula 2-3 liters apply at night and PRN as needed for shortness of breath. Observations on12/03/2024 at 11:34 a.m and 12/04/2024 at 8:10 a.m. inside Resident #18's room, revealed Resident #18's oxygen tubing and nasal cannula were laying coiled loosely on the top of his oxygen concentrator not bagged, and his oxygen/nebulizer mask was lying on the floor behind the oxygen concentrator. During an interview with Resident #18 on 12/03/2024 at 11:36 a.m., Resident #18 stated that he only used oxygen at night and sometimes received nebulizer treatments. He further stated that the Nurse's change out the tubing every Sunday. A second observation on 12/04/2024 at 8:10a.m. inside Resident #18's room with LVN I, revealed Resident #18's oxygen tubing and nasal cannula were still loosely coiled around the top of his oxygen concentrator, and the mask was still lying on the floor behind the oxygen concentrator. In an interview with LVN I on 12/04/2024 at 8:10 a.m., LVN I stated that Resident #18 used oxygen supplementation at night and as needed, and stated the oxygen tubing and mask should be stored in a plastic bag, not on the floor to prevent damage to the tubing and cross contamination. He stated he did not administer the oxygen during the day to Resident #18 and did not know why the tubing and mask were not placed in plastic bag for storage, (continued on next page)

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	675638	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines Nursing and Rehabilitation	3301 E. Mockingbird Lane Victoria, TX 77904

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RCN on 12/04/2024 at 1:55 p.m. the RCN stated oxygen tubing/mask should always be stored in a plastic bag, so that it stays clean and off the floor, and to prevent cross-contamination. She stated that it was the responsibility of the administering Nurse and all the Nurse's working with Resident #18 to ensure that the oxygen tubing/mask was stored correctly in a plastic bag after use. The RCN provided a copy of the facility policy titled Oxygen Administration revised February 13, 2007, but noted that it did not address proper storage of oxygen tubing/masks, and that she did not have any other policy addressing storage of oxygen tubing and masks.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 33866 Based on observation, interview, and record review the facility failed to ensure, in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls in 1 of 2 medication rooms (Annex Medication Room) reviewed for medication storage. The facility failed to ensure one unopened bottle of Latanoprost eye drops was refrigerated until opened. This failure could place residents at risk of medications not being therapeutically effective. Findings included: Observation on 12/04/2024 at 2:05 p.m. of the Annex medication room with LVN-I present, revealed one bottle of Latanoprost 0.0005% solution for Resident # 2 stored in a plastic bag on the medication room counter, at room temperature. The label on the bottle read Refrigerate until opened. The bottle felt warm (room temperature), not cold as if it had recently been taken out of the refrigerator. During an Interview with LVN-I on 12/04/2024 at 2:10 p.m., LVN-I confirmed the bottle of Latanoprost for Resident #2 was unopened and had been found on the counter at room temperature, not inside the refrigerator. LVN-I stated the Latanoprost should have been kept stored in the refrigerator until opened for use, and that by not storing it at correct temperature, the medication may no longer be as effective. LVN-I stated the DON was responsible for maintenance of the medication room, but their DON resigned last week and he was not sure who would now be responsible for maintaining the medication rooms. During an interview with the RCN on 12/05/2024 at 10:25 a.m., the RCN stated that Latanoprost should be stored in the refrigerator until it is opened, at which time it should be labeled with an open date. The RCN stated that it was important to store medications at the recommended temperatures, so they don't lose their effectiveness. Record review of the facility's policy titled, Recommended Medication Storage revised 7/2012, under Section that reads: Below is a list of medication that require a date when opening and recommended time frame the medications should be used: Contained in that list was: Xalatan (Latanoprost Ophthalmic Drops - Refrigerate until initial use and then expires 6 weeks (42 days) when stored at room temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41651 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: 1. There were no foot-operated waste baskets near hand-washing station. 2. A tray of glasses filled with tea were uncovered. 3. Dietary Aide H was not wearing a hairnet that fully covered her hair. 4. Individual packets of salt and artificial sweetener were in the pantry floor. 5. An oily liquid substance was in the pantry floor under a container of fry oil. 6. Flour was in the pantry floor under a container of flour. 7. Dusty debris on the lower shelf of the food preparation counter. These failures could place residents who consumed meals and/or snacks prepared in the facility kitchen in danger of food-borne illness. The findings were: Observation on 12/03/2024 at 10:00 a.m. revealed there were no foot-operated waste baskets near the hand-washing sink. During an interview with Dietary Aide G on 12/03/2024 at 10:00 a.m., Dietary Aide G confirmed there were no foot-operated waste baskets near the hand-washing sink. Observation on 12/03/2024 at 10:05 a.m. revealed Dietary Aide H was wearing a hairnet that did not fully cover her hair. Further observation revealed Dietary Aide H walked by a counter with a tray of glasses filled with tea which were uncovered. During an interview with Dietary Aide H on 12/03/2024 at 10:05 a.m., Dietary Aide H stated she was wearing a hairnet that did not fully cover her hair and stated the tray of uncovered tea glasses had been prepared for the lunchtime meal served at noon. Observation on 12/03/2024 at 10:06 a.m. revealed individual packets of salt and artificial sweetener were in the pantry floor, and some had spilled, leaving salt and/or artificial sweetener in the floor. Further observation on 12/03/2024 at 10:06 a.m. revealed an oily liquid substance was in the pantry floor under a container of fry oil. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Dietary Aide H on 12/03/2024 at 10:06 a.m., Dietary Aide H confirmed the presence of individual salt and sweetener packets, salt and sweetener, and an oily liquid substance in the pantry floor. Observation on 12/05/2024 at 11:25 a.m. revealed flour in the pantry floor under a container of flour. Observation at 12/05/2024 at 11:26 a.m. revealed dusty debris on the lower shelf of the food preparation counter. During an interview with Dietary Aide G on 12/05/2024 at 11:27 a.m., Dietary Aide G stated flour had spilled from the container in the pantry and that there was dusty debris on the lower shelf of the food preparation counter. During an interview with the Dietary Manager on 12/06/2024 at 1:45 p.m., the Dietary Manager stated the findings described above would be rectified. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, 2-402.11, revealed, (A) Except as provided in (B) of this section, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single service and single-use articles. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, 3-305.14 Food Preparation, During preparation, unpackaged food shall be protected from environmental sources of contamination. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 4-602.13 Nonfood-Contact Surfaces, Nonfood-Contact Surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 3-305.1, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. Record review of the facility policy, Kitchen Sanitation, 2012, revealed, We will provide clean and sanitized equipment for food preparation. The facility will clean all food service equipment in a sanitary manner.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923 Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 2 (Hallway A and Hallway E) of 7 resident hallways reviewed for environmental concerns. 1. On resident hallway-A the facility failed to repair: in room [ROOM NUMBER] both sides of the interior bathroom door had 4 inch wood cracks on the bottom of the door, in room [ROOM NUMBER] the phone jack was dislodged from the wall between beds A & B and there was a 2 foot black scrape mark behind the head board of bed A, in room [ROOM NUMBER] there was a black scrape mark on the wall besides the B-bed which measured 2 x2 feet, in room [ROOM NUMBER] there were 2 penetrations on the wall besides the B-bed which measured 7x5 and 1 x 1.5' and at the end of hallway-A there were water marks on 4 of the 2x2' ceiling tiles and 2 other ceiling tiles were removed from the ceiling. 2. On resident hallway-E the facility failed to repair: in room [ROOM NUMBER] both sides of the entry to the bathroom interior door had paint scraped off over a 5 area and the 2x2 ' bathroom ceiling tile was dislodged from the ceiling, in room [ROOM NUMBER] the toilet water was continually running and both sides of the entry to the interior bathroom door had paint scraped off of a 5 area, and across from the TV viewing area a section of the floor molding which measured 4 by 5' was dislodged from the wall. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe. The findings included: 1. During an observation on 12/5/24 from 1:50 p.m. to 2:05 p.m. with the Assistant Maintenance Director and the Administrator revealed the following: a-in room [ROOM NUMBER] on Hallway-A both sides of the interior bathroom door had 4- inch wood cracks on the bottom of both sides of the door b-in room [ROOM NUMBER] on Hallway-A the phone jack was dislodged from the wall between beds A & B and there was a 2' black scape mark behind the head board on bed A, c-in room [ROOM NUMBER] on Hallway-A there was a black scrape mark on the wall besides the B-bed which measured 2 x2' d-in room [ROOM NUMBER] on Hallway-A there were 2 penetrations on the wall besides the B-bed which measured 7x5 and 1 x 1.5.' e-at the end of hallway-A there were water marks on 4 of the 2x2' ceiling tiles and 2 other ceiling tiles were removed from the ceiling. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f.-in room [ROOM NUMBER] on Hallway E both sides of the entry to the bathroom interior door had paint scraped off over a 5 area and the 2x2 ' bathroom ceiling tile was dislodged from the ceiling. g.in room [ROOM NUMBER] on Hallway-E the toilet water was continually running and both sides of the entry to the interior bathroom door had paint scraped off of a 5 area h-across from the TV viewing area on Hallway-E a section of the floor moulding which measured 4 by 5' was dislodged from the wall. During an interview with the Assistant Maintenance Director and the Administrator on 12/5/24 at 2:10 p.m. the Assistant Maintenace Director stated that she was made aware by nursing staff of some of the repairs needed on resident Hallways A & E. She stated the facility would be completing all repairs in the upcoming weeks. The Administrator and Assistant Maintenance Director stated that fixing the areas noted for repiar would provide a more homelike environment for the residents. Record review of the facility's policy on Preventative Maintenance, undated, revealed the policy read that the facility's building, grounds, and equipment would be kept in good repair.