STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675766	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Courtyard Rehabilitation and Healthcare Center	3401 E Airline Dr Victoria, TX 77901

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interviews and record review, the facility failed to ensure the resident had the right to be informed of the risks, and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives, or treatment options and to choose the alternative or options he or she preferred, for 1 (Resident #105) of 8 residents reviewed for resident rights. The facility failed to obtain a signed consent for antipsychotic medication, Escitalopram Oxalate (Lexapro) which was administered to Resident #105. This failure could place residents at risk of receiving medications without their, or that of their responsible party's prior knowledge or consent and could place the residents at an increased risk for adverse reactions to the medications. Findings included: Record review of Resident #105's face sheet, dated 08/21/2024, indicated Resident #105 was an [AGE] year-old female admitted to the facility initially on 08/16/2024 with diagnoses which included: surgical aftercare following surgery on the nervous system, chronic systolic heart failure (a long-term condition that occurs when the heart can't pump blood efficiently enough to meet the body's needs), and presence of cardiac pacemaker (a small, battery-operated device that's implanted in the chest to regulate the heart's rhythm and rate by sending electrical pulses). Record review of Resident #105's admission BIMS assessment dated [DATE] revealed a BIMS score of 11 indicating moderately intact cognition. A complete admission MDS had not yet been completed. Record review of Resident #105's Care Plan, accessed 08/22/2024, indicated Resident #105 had a focus area of antidepressant medication related to depression, initiated 08/21/2024. The intervention was, Educate the resident/family/caregivers about risks, benefits, and the side effects of medication. Record review of Resident #105's Order Recap Report, accessed 08/22/2024, revealed an active order for Escitalopram Oxalate (Lexapro) 20 mg 1 tablet by mouth one time a day, with order date of 08/17/2024 and start date of 08/17/2024. (continued on next page)

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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #105's Medication Administration Record, dated 08/01/2024 - 08/22/2024, revealed Escitalopram Oxalate (Lexapro) 20 mg, 1 tablet by mouth 1 time a day, was noted as administered 08/17/2024 - 08/22/2024. Record review of Resident #105's EHR, accessed on 08/22/2024, revealed there was no consent for Escitalopram Oxalate (Lexapro) in the resident's EHR. During an interview on 08/22/2024 at 12:50 PM, Resident #105 stated the facility never obtained her consent to administer an anti-depressant medication or informed her of the benefits and risks of such a medication. She had a RP who visited her every evening and showered her, per the RP's preference. She did not believe her RP signed a consent for an anti-depressant medication. During an interview on 08/22/2024 at 01:13 PM, the DON stated consents for anti-depressant medications needed to be obtained prior to administering medications and she did not see a consent for Escitalopram Oxalate (Lexapro) in Resident #105's EHR. During an interview on 08/22/2024 at 2:05 PM the Director of Medical Records stated she was responsible for uploading consents for psychotropic medications into residents' EHRs. She uploaded a consent for Lexapro for Resident #105 that afternoon and she had not seen a consent for this medication for Resident #105 prior to the afternoon of 08/22/2024. During an interview on 08/22/2024 at 2:40 PM, LVN C stated Resident #105 asked her to sign the consent for Lexapro on 08/22/2024 on her behalf because that was her preference. She knew Resident #105 was admitted on [DATE], had been administered Lexapro from 08/16/2024 - 08/21/2024, and consents for anti-depressants needed be obtained prior to the first administration of this type of medications; however, she was not the nurse who admitted Resident #105. Record review of the facility's policy titled Psychotropic Medications with a revised date of 12/2023 revealed 7. Upon initial comprehensive assessment, the SSD designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or physician's orders for psychotropic medications. The facility's Interdisciplinary Team (IDT) will review to ensure f. Informed consent was obtained prior to medication use. Record review of the facility provided document Federal Resident Rights revealed: Planning and implementing care. 4. The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment alternatives or treatment options and to choose the alternative or option you prefer.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **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's right to respect and dignity for 2 (Resident #3 and Resident #206) of 18 residents reviewed for respect and dignity, in that: CNA B stood while assisting Resident #3 and Resident #206 to dine. This deficient practice could lead to psychosocial harm due to feelings of low self-esteem and/or embarrassment. The findings were: Record review of Resident #3's face sheet, dated 08/22/2024, revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including: Hypertension, Diabetes Mellitus, and Seizure Disorder. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed a BIMS score of 10 which indicated moderate cognitive impairment. Further review revealed Resident #3 required assistance with dining. Record review of Resident #206's face sheet, dated 08/22/2024, revealed Resident #206 was admitted to the facility on [DATE] with diagnoses including: Down Syndrome, Dementia, and Feeding Difficulties. Further review revealed Resident #3 required assistance with dining. During an observation on 08/21/2024 at 12:40 p.m., CNA B was standing while assisting Resident #206 to dine. During an observation on 08/21/2024 at 12:41 p.m., CNA B was standing while assisting #3 to dine. During an interview with CNA B on 08/21/2024 at 12:42 p.m., CNA B stated she usually stood while assisting residents to dine so that she could be ready to leave the dining room and assist other residents outside of the dining room. CNA B stated she had not received instruction or training from the facility regarding whether to sit or stand while assisting residents to dine. During an interview with the DON on 08/22/2024 at 2:25 p.m., the DON stated staff who assist with feeding residents should sit down to do so and it is her expectation that staff sit to assist residents to dine. Record review of the facility policy, Feeding the Dependent Resident, revised 05/2007, revealed, Sit at eye level of the resident .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on interviews and record reviews, the facility failed to ensure the MDS accurately reflected the resident's status for 1 of 21 residents (Resident #6) whose MDS assessments were reviewed, in that: Resident #6's Quarterly MDS, dated [DATE], did not document the resident was receiving hospice services. This failure could place residents at-risk for inadequate care and services due to an inaccurate assessments. The findings included: Record review of Resident #6's face sheet, dated 08/21/2024 revealed an admitted [DATE], with diagnoses that included: Acute and chronic respiratory failure with hypercapnia (abnormally elevated carbon dioxide levels in blood); Age-related osteoporosis (condition where bones becomes weak/brittle) with current pathological fracture-vertebra; wedge compression fracture of unspecified lumbar vertebra; and Cognitive communication deficit. Record review of Resident #6's Physician Orders dated 08/21/2024 revealed orders for DNR-Do Not Resuscitate status and Admit to Hospice of South Texas DX [diagnosis': Respiratory Failure effective 01/04/2024. Record review of Resident #6's Care Plan dated 06/20/2024 revealed Resident #6 has elected DNR status. No AD [Advance Directive} in place. is on Hospice Services. Record review of Resident #6's Quarterly MDS, dated [DATE], revealed Resident #6 was coded as not receiving Hospice Care. During an interview with the MDS Nurse on 8/22/2024 at 4:55 p.m., MDS Nurse verbally confirmed and stated Resident #6's Quarterly MDS was coded as showing Resident #6 was not receiving Hospice Care. MDS Nurse noted a Significant Change MDS was completed on 01/20/2024 showing Resident #6's change of status to Hospice Care, but she stated through oversight, Hospice Care was not carried over onto her most recent July 2024 Quarterly MDS. The MDS Nurse stated this would cause the MDS to have inaccurate information and inaccurate MDS information could result in Resident #6 not getting the care needed. During an interview with the DON on 08/23/2024 at 10:52 a.m., the DON stated that it was important to have accurate information on the MDS, to ensure residents receive the care they need, because information on MDS helps determine budgeting aspects such as staffing needs.

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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** 36232 Based on interview and record review the facility failed to complete an accurate assessment of each resident's functional capacity for 1 of 8 residents (Resident #39) whose assessments were reviewed. The facility failed to ensure that Resident #39's diagnosis of depression was a focus area in the resident's comprehensive care plan. This deficient practice could affect residents by contributing to inadequate care. The findings included: Record review of Resident #39's face sheet dated 08/21/2024 revealed the resident was a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including: Chronic kidney disease (a condition that occurs when the kidneys are damaged and can't filter blood properly), type II diabetes mellitus (a long-term condition that occurs when the body doesn't produce enough insulin or doesn't use insulin properly) and major depressive disorder (a mental disorder that involves a depressed mood and loss of interest in activities that are typically enjoyable). Record review of Resident #39's quarterly MDS dated [DATE] revealed a BIMS of 12 indicating moderately impaired cognition. Further review revealed Depression (other than bipolar) was checked in Section I - Active Diagnoses. Record review of documents in Resident #39's EHR revealed a Psychological Progress Note dated 08/15/2024 indicating the resident's top target symptom was depression, current rating was 4-Moderate, the goal for therapy was reduction, and the symptoms present were, depression, loss of pleasure/interests, grief/loss issues, memory loss, pain and withdrawal. The resident's plan was to meet with psychological services weekly. Record review of Resident #39's comprehensive care plan, updated 05/24/2024, revealed the diagnosis of depression as was not listed as a focus area. During an interview on 08/23/2024 at 12:35 PM, the MDS LVN stated Resident #39 used to have an order for an anti-depressant, but it was recently discontinued. When the medication was discontinued, she removed the focus area of depression from the resident's care plan because the care plan template was based on the medication. During an interview on 08/23/2024 at 12:40 PM the DON stated the MDS DON was responsible for completing Comprehensive Care plans and she assists from time to time. If a resident had a diagnosis of depression it needed to be a focus area in the resident's care plan even if the resident was not taking medication as part of the resident's holistic plan of care to ensure all her needs are addressed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy Comprehensive Person-Centered Care Planning reviewed/revised 12/2023, revealed: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interview and record review, the facility failed to ensure the resident was not given a psychotropic drug unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 2 (Residents #17 & #105) of 6 residents reviewed for unnecessary medications, in that: 1. The facility failed to reduce the dosage of Resident #17's order for Cymbalta (Duloxetine) in accordance with the pharmacist's recommendation and physician concurrence. 2. Resident #105 was prescribed a psychotropic drug for depression without a documented diagnosis of depression in the clinical record. These deficient practices could place residents at risk of receiving unnecessary psychotropic medications. The findings included: 1. Record review of Resident #17's face sheet, dated 08/23/2024, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including: Cerebral Infarction (the death of brain tissue due to lack of blood flow), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (intense, excessive and persistent worry and fear about everyday situations). Record review of Resident #17's quarterly MDS dated [DATE] revealed a BIMS of 11, indicating the resident had moderately impaired cognition. Record review of Resident #17's comprehensive care plan, updated 06/10/2024, revealed a focus area of Anti-anxiety medication use r/t anxiety disorder, initiated 11/09/2021, revision on 06/10/2024. Interventions included: Educate resident, family/caregivers about risks, benefits and the side effects of anti-anxiety medication drugs being given. Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. Another focus area was, Antidepressant medication use r/t Depression AEB statements of depression, initiated 06/06/2018, revision on 06/10/2024. Interventions included: Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of the Consultant Pharmacist/Physician Communication dated 07/17/2024 revealed, Resident is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for trial dose reduction: Cymbalta 60 mg QD --> Cymbalta 40 mg QD Resident is also taking: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lorazepam 0.5mg BID Physician/Prescriber Response X AGREE __ DISAGREE __ OTHER There was a handwritten signature at the bottom of the document and a handwritten date of 08/02/2024. Record review of Resident #17's Consolidated Physician's Orders, accessed 08/23/2024, revealed an order for: Duloxetine HCL 60 MG Capsule Give 1 capsule by mouth 1 time a day for depression. Start date: 10/15/2022, revision date: 5/01/2024. During an interview on 08/23/2024 at 11:20 AM, the DON stated Resident #17's order for Duloxetine was not reduced from 60 mg to 40 mg as the consultant pharmacist recommended and the resident's physician agreed and should have been. The process for the medication regimen review was the consultant pharmacist reviewed each residents' medication regimen and emailed the recommendations to her the next day. Both she and the Medical Records clerk uploaded the recommendations into the resident's EHR. The Medical Records clerk ensured the recommendations were forwarded to the residents' respective physicians, and she was responsible for ensuring the physicians' responses to the recommendations were received and forwarded to a nurse, who was responsible for making any necessary changes in residents' orders. The process could be improved by having one person responsible, and the consequence of not implementing a dose reduction for a resident's psychotropic medication was the resident received an unnecessary dosage of the medication. 2. Record review of Resident #105's face sheet, dated 08/21/2024, indicated Resident #105 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses surgical aftercare following surgery on the nervous system, chronic systolic heart failure (a long-term condition that occurs when the heart can't pump blood efficiently enough to meet the body's needs), and presence of cardiac pacemaker (a small, battery-operated device that's implanted in the chest to regulate the heart's rhythm and rate by sending electrical pulses). Depression or major depressive disorder were not listed as diagnoses. Record review of Resident #105's admission BIMS assessment dated [DATE] revealed a BIMS score of 11 indicating moderately intact cognition. A complete admission MDS had not yet been completed. Record review of Resident #105's Care Plan, accessed 08/22/2024, indicated Resident #105 had a focus area of antidepressant medication related to depression, initiated 08/21/2024. The intervention was, Educate the resident/family/caregivers about risks, benefits, and the side effects of medication. Record review of Resident #105's Order Recap Report, accessed 08/22/2024, revealed an active order for Escitalopram Oxalate (Lexapro) 20 mg 1 tablet by mouth one time a day, with order date of 08/17/2024 and start date of 08/17/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #105's Medication Administration Record, dated 08/01/2024 - 08/22/2024, revealed Escitalopram Oxalate (Lexapro) 20 mg, 1 tablet by mouth 1 time a day, was noted as administered 08/17/2024 - 08/22/2024. During an interview on 08/22/24 at 01:13 PM the DON stated Resident #105 was prescribed a psychotropic medication for depression without a documented diagnosis of depression in the clinical record and a diagnosis requiring such a medication should have been listed in the resident's record. The facility needed to review its procedures to ensure all the residents' diagnoses were transcribed from documentation received from the hospital. Nursing staff was responsible for ensuring the residents' records were correct and the deficient practice was an oversight. Record review of facility policy Psychotropic Medications, Reviewed/Revised 12/2023, revealed: It is the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record . Residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Definitions: Psychotropic Medication: The Centers for Medicare and Medicaid Services (CMS) defines a psychotropic medication as any drug that affects brain activities associated with mental processes and behavior. This category includes medications in the categories of antipsychotics, anti-depressants, anti-anxiety, and hypnotics. Gradual Dose Reduction (GDR) is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. 2. On admission, the admitting nurses will review the transfer orders for any psychotropic medications. All effort will be made by the Licensed Nurses (LN) to obtain as much history regarding these medications, including prior informed consents, from the previous facility or through resident or resident representative interview. Any information obtained will be documented in the resident's clinical record. 3. The LN shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician. 4. The Attending Physician will review the resident's treatment plan, in collaboration with the consultant pharmacist, to re-evaluate the use of the psychotropic medication and consider whether or not medication can be reduced or discontinued upon admission or soon after admission, during Initial physician admission visit. a. The medical record must show documentation of the diagnosed condition for which a psychotropic medication is prescribed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 36232 Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 facility reviewed for dietary requirements, in that: The DM did not have the appropriate certification, education, or qualifications to serve as the Director of Food and Nutrition Services. This deficient practice could place the residents who consume food prepared from the kitchen at risk of food borne illness and not receiving adequate nutrition. The findings included: During an interview on 08/20/2024 at 10:30 AM, the DM stated she was not a certified dietary manager or certified food service manager, she did not have an associate's or higher degree in food service management or in hospitality, and she had not been a dietary manager in a long-term care facility for over two years. She was enrolled in a program at a local college, had completed all the classes, and was waiting to take the certifying exam. During an interview on 08/22/2024 at 9:15 AM, the HR Director stated the DM was hired by the facility as a CNA/CMA on 05/11/2022 and assumed the position of DM on 07/10/2023. During an interview on 08/22/2024 at 9:45 AM, the consultant RD stated did not work at the facility full time. In addition to serving as the consultant RD for the facility, she was the course director for the dietary manager's program at the college the DM attended. The DM had completed all the classes, she was missing a few preceptor hours, and had yet to take the exam to become a certified dietary manager. During an interview on 08/22/2024 at 4:30 PM, the Administrator stated there were several interim DMs between the facility's last DM and the present one, who was promoted to the position in 2023. She was aware the DM was not a certified dietary manager or certified food service manager and did not meet any of the other qualifications for the position but anticipated she would pass the exam shortly. During an interview on 08/23/2024 at 11:45 AM, the DON stated the facility did not have a policy on the requirements for the position of DM. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 1-201.10.10(B) Accredited Program. (1) Accredited program means a food protection manager certification program that has been evaluated and listed by an accrediting agency as conforming to national standards for organizations that certify individuals. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2-102.12.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interview and record review, the facility failed to maintain resident medical records that were complete and accurately documented for 1 (Resident #105) of 8 residents reviewed for clinical records. 1. The facility failed to include multiple diagnoses on Resident #105's face sheet and list of diagnoses. 2. Resident #105 was administered supplemental oxygen without a physician's order. These failures could place residents at risk of not having accurate medical records and could create confusion in services provided or needed to be provided. Findings included: 1. Record review of Resident #105's face sheet, dated 08/21/2024, indicated Resident #105 was an [AGE] year-old female admitted to the facility initially on 08/16/2024 with the diagnoses: surgical aftercare following surgery on the nervous system, chronic systolic heart failure (a long-term condition that occurs when the heart can't pump blood efficiently enough to meet the body's needs), and presence of cardiac pacemaker (a small, battery-operated device that's implanted in the chest to regulate the heart's rhythm and rate by sending electrical pulses). Record review of Resident #105's admission BIMS assessment dated [DATE] revealed a BIMS score of 11 indicating moderately intact cognition. A complete admission MDS had not yet been completed. Record review of Resident #105's EHR revealed the resident's hospital discharge paperwork immediately prior to admission indicated she had chronic kidney disease state IIIB with anemia and must avoid nephrotoxic (damaging to the kidneys) medications. The resident also had a past medical history of anxiety, a cerebrovascular accident (loss of blood flow to the brain), atrial fibrillation (irregular heartbeat), gastroesophageal reflux disease (when stomach contents move into the esophagus), mood disorder and hypertensive disorder (high blood pressure). During an interview on 08/22/2024 at 2:10 PM the DON stated Resident #105's list of diagnoses and face sheet were missing several diagnoses, and that failure to properly transcribe all the diagnoses from hospital discharge paperwork could result in improper or potentially life-threatening treatment should the resident be admitted to the ER. It was the responsibility of the admitting charge nurse to ensure all pertinent diagnoses were transcribed into the resident's EHR. 2. Observation on 08/22/2024 at 1:51 PM revealed Resident #105 was receiving oxygen from an oxygen concentrator at the rate of 2L/min. Record review of Resident #105's TAR revealed Oxygen was not listed as a treatment on the TAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675766	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Courtyard Rehabilitation and Healthcare Center	3401 E Airline Dr Victoria, TX 77901

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #105's consolidated physician orders revealed there was no order for supplemental oxygen. Record review of Resident #105's H&P from the discharging hospital revealed, Resident #105 is oxygenating well on 2L nasal cannula. During an interview on 08/22/2024 at 3:05 PM the DON stated Resident #105 was receiving supplemental oxygen at a rate of 2L/min via nasal cannula, there was no physician's order for supplemental oxygen to be administered and there should have been such an order prior to the administration of the oxygen. During an interview on 08/22/2024 at 5:53 PM, LVN D stated she worked the evening shift the day Resident #105 was admitted and she should have put the order for oxygen at 2L/min via nasal cannula in Resident #105's consolidated orders, as this order was to be continued from the resident's hospital stay and she had received verbal confirmation from the resident's physician to continue this order but forgot to do so. Record review of facility policy, Charting and Documentation, revised 05/2007, revealed, The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Is also necessary to include data needed for identification and communication with family and friends. Complete history of resident and present illness is required under current law and regulations at the time of admission. Record review of facility policy, Physician Orders, revised 03/2023, revealed, It 1s the policy of this facility that drugs shall be administered only upon the written order of u person duly licensed and authorized to prescribe such drugs. It 1s the policy of this facility to accurately transcribe and implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. 3. Admission orders are reviewed with the physician upon admission based on the discharge instructions from the discharging facility and are transcribed accordingly. There is a double check system to verify accuracy of order transcription. 6. Medication, treatment or related orders are transcribed in the eMAR, eTAR. 7. Orders for medications must include: A. Name end strength of the drug; B. Quantity or specific duration of therapy; C. Dosage and frequency of administration: D. Route of administration if other than oral; and E. Reason or problem for which given.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 28 residents (Residents #7, #10 and #39) reviewed for infection control, and those residents who eat from meal trays in their rooms, in that: 1. LVN-A did not wash or sanitize her hands in between medication administration for Residents #7, #10 and #39. 2. CNA-B failed to wear gloves or wash hands with soap/water after obtaining used food tray following noon meal, from Resident #206's room, who was on contact precautions isolation for C-diff. These deficient practices could place residents at-risk for infection due to improper care practices. The findings included: 1. Record review of Resident #7 face sheet dated 08/23/2024, revealed an admitted ,d+[DATE]//2022 with diagnoses that included: unspecified dementia (decline in cognitive abilities), Anxiety disorder (mental disorder characterized by feelings of worry, anxiety or fear), adjustment disorder with depressed mood (excessive reactions to stress that involve negative thoughts and changes in behavior), cognitive communication deficit, and presence of cardiac pacemaker, Record review of Resident #7's physician orders dated 08/23/2024 revealed orders that included: Gabapentin Oral Capsule 100mg, give 1 capsule by mouth. Record review of Resident #10's face sheet, dated 08/23/2024 revealed an admitted [DATE] with diagnoses that included: Parkinsonism unspecified (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), dysphagia (difficulty swallowing), cognitive communication deficit, delusional disorder, schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), and transient cerebral ischemic attack (mini-stroke). Record review of Resident #10's physician orders dated 08/23/2024 revealed orders that included: Gabapentin Oral Capsule 100mg, give 1 capsule by mouth three times a day for neuropathy and Valproate Sodium Oral Solution 250mg/5ml-give 10ml by mouth three times a day for seizures. Record review of Resident #39's face sheet dated 08/23/2024 revealed an admitted [DATE] and diagnoses that included: Hypertensive Heart and Chronic Kidney disease with Heart Failure, Dysarthria (slurred speech) and Anarthria (severe motor speech impairment), Elevation of levels of liver transaminase levels, Hyperlipidemia, Essential (primary) hypertension, long term (current) use of insulin, Major Depressive Disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #39's physician orders dated 08/23/2024 revealed orders that included: Calcitriol Capsule give one capsule by mouth three times a day for supplement GIVE 0.25MCG and Potassium Chloride ER Tablet Extended Release 20 MEQ give one tablet by mouth two times a day for hypokalemia . Observation on 8/21/2024 at 4:04 p.m. revealed LVN-A administered Gabapentin 100mg 1 cap, opened and mixed with jelly, and 10ml's of Valproic Acid 250mg/5ml liquid solution to Resident #10. Resident #10 dribbled a small amount of the Valproic Acid solution from the side of his mouth which LVN-A wiped away with a tissue and ungloved hand. LVN-A then returned to the medication cart without washing/sanitizing her hands and proceeded to prepare medication for Resident #7. LVN-A administered medications to Resident #10, then to Resident #7 and then Resident #39 without washing/sanitizing her hands in between each resident. During interview with LVN-A on 8/21/2024 at 4:20 p.m., LVN-A stated the protocol was to sanitize hands before and after administering medications to each resident, and stated she thought that she had sanitized her hands using the alcohol dispenser on the wall a few feet away from her medication cart. When questioned further, LVN-A stated she sanitized her hands at least one time. LVN-A stated that not sanitizing hands in between medication administration for different residents could result in the spread of infection. During interview with DON on 8/23/2024 at 10:52 a.m., the DON stated that Nurses and medication aides needed to wash or sanitize their hands before and after administration of medication to each resident, and that not doing so could result in the spread of germs. Record review of facility policy Infection Prevention and Control Program revised/reviewed 12/2023 reveals Facility personnel will wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Record review of facility policy Administration of Medications revised 5/18/2023 reveals Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. 2, Record review of Resident #206's face sheet dated 8/23/2024 revealed an admitted [DATE] with readmission on 08/12/2024 and diagnoses which included: Urinary Tract infection, Enterocolitis due to Clostridium Difficile (inflammation of colon caused by the bacteria Clostridium Difficile which can becomes spores that have a protective coating allowing them to live for months/years on surfaces - also known as C-diff), Unspecified dementia (decline in cognitive abilities) and Adult failure to thrive. Record review of Resident #206's Physician Orders dated 08/23/2024 revealed orders that included: Contact Isolation R/T [related to] C Diff. Observation and interview on 08/21/2024 at 1:04 p.m. revealed CNA-B collecting used meal trays on Hall 200 and placing them on meal cart with ungloved hands. When CNA-B reached Resident #206's room which had an Isolation Sign posted on the door and PPE (personal protective equipment) supplies at the entrance, CNA-B took Resident #206's used meal tray from a family member standing at the doorway, with ungloved hands, placed the meal tray on the meal cart with the other used trays, sanitized her hands with alcohol, and then proceeded into the next residents' room, collecting used trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA-B stated she knew Resident #206 was in isolation but did not know what she was in isolation for. CNA-B stated staff are supposed to sanitize hands after contact with someone on isolation, but was not aware of need to wear gloves or wash hands with soap and water after contact with Resident #206 or when handling equipment/items used directly with Resident #206 such as her meal tray. Interview on 08/21/2024 at 1:37 p.m. with the DON confirmed Resident #206 was on Contact Precautions for C-diff, and that staff should wash hands with soap and water after touching meal trays that had been used with someone with C-Diff, and that the meal tray should be sanitized, or disposable tableware used. DON stated that failure to follow protocol about hand washing or sanitizing trays could result in spread of infection. Record review of facility IPCP Standard and Transmission-Based Precautions dated 6/2021, revision/review date of 10/2022. Under Contact Precautions, it notes Transmission-based precautions are used with a known infection that is spread by direct or indirect contact with the resident or the resident's environment (e. g. MDROs). The Policy further states contact precautions/isolation are required for patients with MDRO's (Multi-drug Resistant Organisms) with: acute diarrhea . and staff should [NAME] [put on] PPE upon room entry, then doff [remove] and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens. Under Handling of Dishes it states All tableware, whether used by infected or non-infected residents, should be treated as contaminated and should be sanitized according to facility policy. Record review of current CDC Guidelines for C-Diff dated 03/05/2024, revealed Wear gloves and a gown when treating patients with C.diff , even during short visits. Gloves are important because hand sanitizer doesn't kill C.diff. Record review of CNA-B RELIAS training transcript dated 8/21/24 shows CNA-B received training in Infection Control for Nurse Aides, Infection Control Basic Concepts, and Infection Prevention and Control Basics on 7/31/24.