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	09/29/2021

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on record review and interview, the facility failed to transmit a resident assessment within the required time frame for 1 of 3 (CR #2) records reviewed for data encoding and transmission as evidence by: The facility did not transmit a discharge MDS or sign off as completed for CR #2's . discharged MDS was signed as completed and transmitted after the assessment reference date of 5/27/2021. This deficient practice could place residents who discharged at risk of not having their assessments completed and transmitted timely. Findings Include: Record review of CR #2's face sheet dated 09/27/21 revealed he was a 55- year -old male admitted to the facility on [DATE]. His diagnoses included Osteomyelitis left ankle (inflammation or swelling that occurs in the bone) kidney failure, Diabetes, and essential hypertension. Record review of CR # 2's clinical records revealed the last completed MDS was a quarterly MDS dated ARD of 05/19/21 signed as completed on 05/30/21. Electronic record review revealed CR #2 was sent out toER on [DATE]. Record review revealed an open MDS with ARD date of 05/27/21 revealed section A-2000 was checked as D\C return anticipated. Further review revealed MDS was not completed and transited within the required timeframe following the resident's discharge .The resident did not return to the facility as of 09/24/2021. Record review of nurse's notes dated 5/27/2021 read in part- 07:31(AM) Health Status Note: Resident in stable condition, complain of nausea/vomitting,x2,V/S B/P 103/95,R 18,T 96.9,noted with elevated pulse of 133.Zofran 4mg given one time, not effective,x2 more Emesis noted.MD notified of resident status, awaiting call back, Resident left facility to North Cypress Medical Center ER in the company of two Dialysis EMS staff who states it's their company's policy to take resident to the ER since he cannot make it to dialysis today. Resident left to theER on a stretcher in stable condition for further evaluation and treatment. Resident is his own RP and is aware of current status. DON and resident son aware of resident status and Transfer. MD called back, voicemail left on the answering service . (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

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the MDS coordinator on 09/24/21 at 1:00 PM, she said she was responsible for completing all MDS and ensuring that the MDS reflect the resident's condition. She said she had been at the facility for one month and was trying to update all the MDS and care plans. She said the MDS should have been completed. Record review of facility policy dated 2001 revised 02/2014 titled Resident Examination and Assessment read in part -:Purpose: The purpose of this is to examine and assess the resident for any abnormalities in the health status which provides a basis for the care plan .

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observation, interview, and record review, the facility failed to ensure the assessment accurately reflected the residents's status for 3 of 20 (Residents #9, #12 and #18) residents reviewed for comprehensive assessment accuracy in that- 1 Resident #9 was not assessed for his identifying information (race\ethnicity facility) and his dental status. 2 Resident #12 was not assessed for his vision on the his admission MDS dated [DATE] and Resident # 12 was not assessed for a his fall on the his Quarterly MDSs dated 02/14/21. 3 Resident #18 was not assessed for his functional limitations on her the admission MDS dated [DATE]. Theses failures could place residents at risk of inaccurate assessments and not having their needs met. Findings included: 1. Record review of Resident #9's face sheet dated 09/22/21 revealed he was a 64- year -old male admitted to the facility on [DATE]. His diagnoses included Cerebral infarction(stroke) bacterial infection, Cerebral vascular disease (heart diseases), depression, and benign prostatic hyperplasia (prostate gland enlargement). Record review of Resident # 9's Annual MDS, with ARD date of 01/05/21 and completed 09/22/21, revealed his BIMs score was coded as 13 out of 15 indicating he was mildly impaired cognitively. The MDS revealed the following- - Section A 1000 of the MDS regarding - Race\ethnicity was left blank and Section L on oral\dental status was coded as 0 (having all-natural teeth). Observation and interview on 09/21/25 at 10:30 AM, revealed Resident #9 was in his room on his wheelchair alert and oriented. He answered all questions relating to his health. When asked the last time he saw a dentist, he said it had been a long time and he would like to visit one because he had some loose teeth that bother him from time to time. He said he did not remember the date and time, but he would like to see one. 2. Record review of Resident #12's face sheet dated 09/22/21 revealed he was a 78- year -old male admitted to the facility on [DATE]. His diagnoses included heart failure, hypertension (high blood pressure), post Covid, heart diseases, chronic kidney disease, and depression. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's Admission MDS dated [DATE] revealed his BIMs score was 10 out of 15 indicating he was moderately impaired cognitively. Section B of the MDS on vision was coded 0 meaning he sees adequately. Record review of Resident #12's Quarterly MDS dated [DATE] and completed on 02/18/21 revealed his BIMs score was 10 out of 15 indicating he was moderately impaired cognitively. Section J of the MDS on fall history was coded 0 meaning no fall since admission. Observation and interview on 09/21/21 at 11:00 AM, revealed Resident #12 was on his bed, in his room,. he was alert and oriented. During an interview at this time he said he was not doing well, he said he had a cataract in his eye and cannot see very well. He said he went to his doctor Dr. to get eye surgery and was diagnosed with COVID-19. He said he does not understand how and why he end up in a nursing home. He said he needs to see his eye doctor, and his dentist. He said he had been telling the nursing staff what hehis needs are, but no one listened to him. Record review of nursing notes dated 1/28/2021 at 3:15 PM read in part-Nurse found patient on the floor, he is alert and awake and confused , patient is move from the floor to his bed with 2 nurses , he sustain scrapes and bruises on his right upper arm , site is clean with NSS pat dry wound nurse is notify also. Patient right arm is dress per wound nurse. all vitals are taken and are within normal limit, 142/76, 97.8, 78bpm 20 98% DON is notify Dr and family member also notify, will continue to monitor for safety on my shift. 3. Record review of Resident #18's face sheet dated 09/27/21, revealed she was a 48- year -old female admitted to the facility on [DATE]. Her diagnoses included Sepsis (infection), respiratory failure, (inability to breath), Cerebral Vascular diseases (disorders that affect the blood vessels and blood supply to the brain) Heart failure, hypertension (high blood pressure) and muscle weakness. Record review of her Admission MDS dated [DATE] signed as completed on 02/02/21 revealed section G functioning limitation was coded 0 on upper and lower extremity meaning no impairment. Observation on 09/21/21 at 10:20 AM, revealed Resident #18 was in bed sleeping, a Catheter was noted to her bed side with 200 CC of yellow clear urine. She had a G-Tube feeding going was on at 65 cc per hour. Attempt was made to communicate with to Resident #18, but she did not respond verbally, she opened her eyes. and slept off. Observation on 09/22/21 at 1:00PM revealed Resident #18 was awake, alert and oriented. She was being fed feed by LVN L, she ate 100% of served lunch. During an interview at this time she said her lunch was good. She said she was not able to use her right leg and hand. She said she hope she would get better to start walking again. Record review of her Admission MDS dated [DATE] signed as completed on 02/02/21 revealed section G functioning limitation was coded 0 on upper and lower extremity meaning no impairment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the MDS coordinator on 09/24/21 at 1:00 PM, she said she was responsible for completing the MDS and ensuring that the MDS reflect the resident's condition. She said she had been working at the facility for one month and was trying to update all MDS and care plans. She said she had no explanation as why the MDS did not reflect her condition. She said she had no explanation. Record review of facility policy dated 2001 revised 02/2014 titled Resident Examination and Assessment read in part - Purpose: The purpose of this is to examine and assess the resident for any abnormalities in the health status which provides a basis for the care plan .

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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** 16352 Based on observation, interviews, and record review, the facility failed to develop a comprehensive person - centered care plan for each resident that described the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being for 1 of 3 residents (Resident #7) reviewed for care plans in that: Resident #7's comprehensive care plan did not reflect the resident's urinary status as the use of a catheter instead of being incontinent of bladder. This deficient practice could affect residents at the facility who require a care plan and place them at risk for not receiving the appropriate care and services needed to maintain optimal health. The findings were: Record review of the admission sheet for Resident #7 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension, (high blood pressure), cerebral vascular accident (stroke), recurrent urinary tract infection, trans metatarsal (limbs) amputation, peripheral vascular disease (poor blood flow to extremities), diabetic mellitus (high blood glucose) , hyperlipidemia (high cholesterol), sepsis (infection)with acute hypoxia (low oxygen), acute kidney injury , morbid obesity (very fat) due to excess calories. Record review of Resident #7's MDS dated [DATE] revealed a BIMS score of 15 indicating cognition intact. Further review revealed that Resident #7 required extensive assistance in the following areas: bed mobility, dressing, and personal hygiene. Further review revealed that Resident #7 required total assistance with toilet use and was always incontinent of bowel and bladder Record review of Resident #7's clinical physician orders dated 06/21/2021 revealed orders for Resident #7 to have a Foley16 Fr. (French) catheter with a 10 cc (cubic centimeters) bulb (used to hold the catheter in place) and to change out every month and as necessary. Record review of Resident #7's admission MDS dated [DATE] revealed in section H0100. Appliances section A. the resident had an indwelling catheter and section H0300. Urinary Incontinence not rated (9.). Record review of Resident #7's quarterly MDS dated [DATE] revealed in section H0100. Appliances section A the resident had an indwelling catheter and in section H300. Urinary Incontinence not rated (9.). Record review of Resident #7's comprehensive care plan dated 06/21/2021 with a revision on 09/24/2021 revealed Resident #7 had a problem area for bladder incontinence and an indwelling catheter revision on 09/24/21 and were not initiated on 06/21/2021. Observation on 09/21/2021 at 12:04 AM, revealed Resident #7 had a Foley catheter and the urine was draining into a drainage bag. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/24/21 at 4:26 PM, Resident #7 was noted to have an indwelling Foley Catheter in place. In an interview on 09/23/21 at 11:45 a.m., the MDS Coordinator said that she had been working for the facility for six weeks and she was responsible for updating care plans. She said that when she started working in the facility she noticed that all the care plans were not updated and she reported it to the DON and Administrator and they hired another nurse to help with updating care plans from home but they are still behind with updating and revising care plans. She said that she did not attend the clinical meeting and she only got the updates from the nurse's progress notes and if the nurses don't document then she will not be able to know if there was a change with residents treatment or condition hence that care plan won't be updated. She said that she had talked to the nurses about their documentation, but some of the changes on residents were not documented. She said that she did rounds with the charge nurses and if they reported to her any change in condition of residents or new treatments then she would update the care plan. During an interview on 09/23/2021 at 4:40 p.m., the MDS coordinator confirmed Resident #7's comprehensive care plan with revision date 09/24/2021 should have been changed from bladder continence to an indwelling Foley catheter care plan. When asked why it was not taken off the MDS coordinator stated I just missed it. During an interview with the DON on 9/24/21 at 3:30 PM she said the facility had problem updating care plan because the MDS nurse quit and they just hired a new nurse for MDS about two months ago. DON said she knew the new MDS nurse was working very hard to update the care plan Record review of the facility policy and procedure titled Comprehensive Care Planning, page GP MC 03-18. 0, undated, read, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment Care planning drives the type of care and services that a resident receives .The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44130 Based on observation, interview, and record review the facility failed to develop, update and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident medical, nursing, mental, and psychosocial needs for 6 (Resident #18 ,#9, #10, #12,#296, and #297) of 20 residents reviewed for care plans. The facility failed to ensure that Resident #18',#9,#10, #12,#296, and #297, care plan were updated to include the following areas as triggered on her admission MDS section V CAAs as followed-her discontinued tracheostomy, oral feeding, Mood, Activities, communication , cognition, new treatments and change in condition These failures could place residents at risk of receiving inadequate car and interventions needed to maintain \improved their health condition. Findings Included: Resident #12 Record review of Resident #12's face sheet dated 09/22/21 revealed he was a 78- year -old male admitted to the facility on [DATE]. His diagnoses included Heart failure, hypertension (high blood pressure), post Covid, heart diseases, chronic kidney disease and depression. Record review of Resident #12's Admission MDS dated [DATE] revealed his BIMs score was 10 out of 15 indicating he was moderately impairment cognitively. Record review of Resident # 12's Admission MDS dated [DATE]section V CAA revealed Resident #12 was triggered for mood, dental and Activities. Record review of nursing notes dated 1/28/2021at3:15 PM written by, read in part-Nurse found patient on the floor, he is alert and awake and confuse , patient is move from the floor to his bed with 2 nurses , he sustain scrapes and bruises on his right upper arm , site is clean with NSS pat dry wound nurse is notify also. Patient right arm is dress per wound nurse. all vitals are taken and are within normal limit, 142/76, 97.8, 78bpm 20 98% DON is notify Dr and family member also notify, will continue to monitor for safety on my shift. Record review of Resident#12's care plan dated 01/13/21 revealed no evidence of care plan for activities, mood, and dental. Care plan was not updated after the assessment dated [DATE]. Record review of Resident #12's care plan dated 04/12/21 revealed the care plan was not updated to reflect resident #12's fall of 01/28/21 Resident #18 (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's face sheet dated 09/27/21 revealed she was a 48- year -old female admitted to the facility on [DATE]. Her diagnoses included Sepsis (infection), respiratory failure, (inability to breath), Cerebral Vascular diseases (disorders that affect the blood vessels and blood supply to the brain) Heart failure, hypertension (high blood pressure) and muscle weakness. Record review of Resident #18's care plan dated 02/01/21 read in part - Resident #18 has a tracheostomy r/t Impaired breathing mechanics due to respiratory failure. Date Initiated: 02/01/2021 Record review of therapy's note dated 02/01/21 revealed Goal- Resident # 18 will have no abnormal drainage around trach site through the review date. Date Initiated: 02/01/2021. Target Date: 05/03/2021. Intervention- Ensure that trach ties are secured at all times. Date Initiated: 02/01/2021. Observe/document for restlessness, agitation, confusion, increased heart rate (Tachycardia), and bradycardia. Observe/document level of consciousness, mental status, and lethargy PRN. Date Initiated: 02/01/2021. Observe/document respiratory rate, depth and quality. Check and document every shift/as ordered. OXYGEN SETTINGS: Oxygen @2 Liters via (nasal cannula/mask/trach) as needed Date Initiated: 02/01/2021 Observation on 09/21/21 at 10:20 AM revealed, Resident # 18 she was in be sleeping Catheter to her bed side with 200 CC of yellow clear urine, G-Tube feeding was infusing at 65 cc per hour. Attempt was made to communicate to Resident #18, but she did not respond. She opened her eyes and slept off. Observation and interview on 09/21/21 at 1:00PM, revealed Resident #18 was up looking around. Feeding Tube was D\C. Observation revealed LVN L feeding Resident #18 a Puree diet. LVN L said Resident #18's feeding tube was to be on from 6:00AM to 6:00PM. She said Resident #18 was on a Puree Diet and her tracheostomy had been discontinued a long time ago Record review of a Therapy note dated 02/05/21 at10:09 AM, written by read in part- Received report on Resident #18 at this time, resident decannulated self on the previous shift. Resident remains on 02 Via cannula to maintain 02 at 92% or greater . Record review of Resident #18's Admission MDS dated [DATE] revealed she was triggered for following- mood, activities, communication and cognition. Record review of Resident #18's care plan revealed 02/21 revealed no evidence of care plan for the following- mood, activities, communication and cognition. During an interview with the MDS coordinator on 09/24/21 at 1:00 PM, she said she was responsible for completing all MDS and ensuring that the MDS reflect the resident's condition. She said she was one month old at the facility and was trying to update all the MDS and care plans ,she said she had no explanation for why the care plan were not updated . Resident #9 Record review of Resident #9's Admission Record dated 09/24/21 revealed Resident #9 was [AGE] years-old and was admitted to the facility on [DATE]. Resident #9's diagnoses included Hypertension, Acute respiratory failure, Cardiac arrest, dependence on ventilator, Diabetic type 2, and Pneumonia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's Quarterly Minimum Data Set (MDS) assessment, dated 09/03/2021, revealed Resident #9 was severely cognitively impaired with a BIMS score of 0 and required extensive assistance from staff for bed mobility, transfers, locomotion, and total dependence with dressing, toilet use, and personal hygiene. Record review of Resident #9's fall incident report dated 08,31/21 and 09/08/21 revealed that Resident #9 had a fall on 08/31/2021 and on 09/08/21. Record review of Resident #9's comprehensive care plan dated 08/27/21, revealed that the care plan was not revised when the resident fell on [DATE] and on 09/08/21. In an interview on 09/23/21 at 11:45 a.m., registered nurse (RN/MDS Coordinator said that she had been working for the facility for six weeks and she was responsible for updating care plans. She said that when she started working in the facility she noticed that all care plan were not updated and she reported it to the DON and Administrator and they hired another nurse to help with updating care plans from home but they are still behind with updating and revising care plans. She said that she did not attend the clinical meeting and she only got the updates from the nurse's progress notes and if the nurses don't document then she will not be able to know if there was a change with residents treatment or condition hence that care plan won't be updated. She said that she had talked to the nurses about their documentation, but some changes on residents were not documented. She said that she did rounds with the charge nurses and if they reported to her any change in condition of residents or new treatment then would update the care plan. She said the charge nurses did not update MDS coordinator about Resident #9 falls on 08/31/21 and 09/8/21 that was why the care plan was not updated with dates of the falls and interventions. She said that on 09/22/21 the clinical team that included the DON, ADONs and MDS coordinator had a meeting and they will start updating the fall care plans. In an interview on 09/23/21 at 12:00 PM, ADON B said that the MDS coordinator was responsible for updating care after the completion of the MDS assessments and acute changes such as falls or any change in condition in residents, she said the floor nurses were responsible for updating the care plan. Resident #10 Record review of Resident #10's Admission Record dated 09/24/21 revealed Resident #10 was [AGE] years-old and was admitted to the facility on [DATE]. Resident #10's diagnoses included Cerebral palsy, major depression, heart failure and anxiety. Record review of Resident #10's Significant change in status Minimum Data Set (MDS) assessment, dated 07/23/2021, revealed Resident #10 was severely cognitively impaired with a BIMS score of 0 and required extensive assistance from staff for bed mobility, transfers, locomotion, with dressing, toilet use, and personal hygiene. Observation on 09/21/21 at 10:56 AM, of room [ROOM NUMBER]A, Resident #10 was not in bed and the bed was not made but observed outside the room close to the nurse's station sitting on the wheelchair. Observed resident with contractures to bilateral (both) upper extremities, surveyor attempted to talk to Resident #10 but she did not respond. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/22/21 at 11:52 AM, the COTA (certified occupation therapist assistant) said that Resident #10 was on specialized services and had a splint ordered for resident to wear for 4 hours. Record review of Resident #10's dated 8/25/21 therapy daily documentation revealed that Resident #10 was a PASRR positive and was on specialized services speech, Physical and occupation habilitative therapy. Record review of Resident #10's comprehensive care plan dated 01/18/2006 revealed that the centered care was identified as having PASRR positive related to intellectual disability and developmental disability. Person-centered comprehensive care plan was not revised when the resident specialized services were initialed. Care plan not addressing the contractures or interventions. Resident #297 Record review of Resident #297 Admission Record dated 09/24/21 revealed Resident #297 was [AGE] years-old and was admitted to the facility on [DATE]. Resident #297's diagnoses included Hypertension, cerebral infarction, Acute respiratory failure, dependence on ventilator, Diabetic type 2, dependence on renal dialysis, end stage renal disease and major depression. Record review of Resident #297's Quarterly Minimum Data Set (MDS) assessment, dated 08/27/2021, revealed Resident #297 was severely cognitively impaired with a BIMS score of 0 and required total assistance from staff for bed mobility, transfers, locomotion, and dressing, toilet use, and personal hygiene. During an interview on 09/21/21 at 10:21 AM, Resident #297's family member said she felt that the dialysis company was not doing a good job with her Resident #297's dialysis. She said that Resident #297 had hypotension when she went to dialysis Resident #297's BP would drop, and she was unable to complete dialysis and she felt like that had caused her to have a lot of fluids. She said that Resident #297 was on a medication to raise the blood pressure, but she did not know the name of the medication and the medication was PRN but it was changed to a scheduled dose after she asked the nurses to notify the primary physician. She said that she wanted the medication to be prn as well so that when Resident #297 blood pressure drops, she would have it. She said that she talked to the administrator, and DON, they said they were going to talk to the dialysis nurses. She said that Resident #297 admitted with fluid to both arms, but it had gotten worse. She said that she thought that the dialysis nurses and the facility do not care concerning Resident #297's dialysis and the fluids she had accumulated because dialysis was not pulling enough fluids. Record review of Resident #297's physician orders revealed that Resident #297 had an order for midodrine 10mg (1) tablet via feeding tube every 8 hours for hypotension. Review of the nurse notes dated 08/08/21,08/23/21, 09/04/21,09/13/21 and 09/14/21 revealed that Resident #297 had +3 edema and +4 documented on 07/23/21. Record review of Resident #297's comprehensive care plan dated 08/23/21 revealed that the centered care was not addressing midodrine 10mg I tablet via feeding tube every 8 hours for hypotension and the 3+ to 4+edema. (continued on next page)

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Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #296 Record review of Resident #296 Admission Record dated 09/24/21 revealed Resident #296 was [AGE] years-old and was admitted to the facility on [DATE]. Resident #296's diagnoses included tracheostomy status, Acute respiratory failure, major depression, dependence on ventilator, Diabetic type 2, and dependence on renal dialysis. Record review of Resident #296's Admission Minimum Data Set (MDS) assessment, dated 07/26/2021, revealed Resident #296 was severely cognitively impaired with a BIMS score of 0 and required extensive assistance from staff for bed mobility, and total dependence with dressing, toilet use, and personal hygiene. Observation on 09/21/21 at 10:10 AM, Resident #296's room resident was out for dialysis, feeding tube formula was on the table, canister on the bedside table had bloody secretions' that was suctioned from resident . Record review of Resident #296's physician orders revealed that Resident #296 had tracheostomy, feeding tube and was on dialysis 5 times per week. Further review of Resident #296's physician orders revealed order for medication of Eliquis 2.5mg daily via G- Tube. Record review of Resident #296's comprehensive care plan dated 07/22/21 was not revised with the resident medication of Eliquis 2.5mg and the bleeding condition during suctioning. During an interview on 09/22/21 at 12:00 PM, the respiratory therapy director said that he had 12 staff under his supervision that worked 12-hour shifts. He said that he is aware of Resident #296 bloody secretions and he notified the nurses but did not notify the physician. He said he did not know what was causing Resident #296's bleeding during suctioning but in most cases maybe because of suctioning too much, not having enough humidity or positioning. He said that Resident #296 may need a scope to be able to know what was causing the bleeding and the resident had not been seen by a pulmonologist for the bleeding, and he had not communicated with the physician. He said that the Resident #296 had the episodes of bloody secretions during suctioning on and off since admission to the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/23/21 at 11:45 a.m., Registered Nurse (RN/MDS Coordinator said that she had been working for the facility for six weeks and she was responsible for updating care plan. She said that when she started working in the facility she noticed that all care plan were not updated and she reported it to the DON and Administrator and they hired another nurse to help with updating care plan from home but they are still behind with updating any revision care plan. She said that she did not attend the clinical meeting and she only got the update from the nurse's progress notes and if the nurses don't document then she will not be able to know if there is a change with residents treatment or condition hence that care plan won't be updated. She said that she had talked to the nurses about them documentation, but some of changes on residents are not documented. She said that she did rounds with the charge nurses and if they reported to her any change in condition in residents or new treatments then she would update the care plan. She said that the charge nurses did not update her about Resident #1 midodrine 10mg I tablet via feeding tube every 8 hours for hypotension and the 3+ edema that was why the care plan was not revised or updated. She said that on 09/22/21 the clinical team that included the DON, ADONs and MDS coordinator had a meeting and they will start updating the care plans. In an interview on 09/23/21 at 12:00 PM, ADON B said that MDS coordinator was responsible for updating care plans after the completion of the MDS assessments and acute changes such us falls or any change in condition of residents the charge nurses were responsible for updating the care plan. In an interview on 09/24/21 at 03:01 p.m., the Director of Nurses (DON) said the facility had written policies on comprehensive care plans and she said that completion of the care plan was an IDT (interdisciplinary team) approach. The DON said the MDS coordinator was responsible for updating the care plan after the completion of the MDS assessments and the charge nurses were responsible for updating the care plan for any acute changes such as falls or any change in condition of residents. Record review of facility policy dated 2001 revised 02/2014 titled Resident Examination and Assessment read in part -Purpose-The purpose of this is to examine and assess the resident for any abnormalities in the health status which provides a basis for the care plan. Review of care plans, Comprehensive person center policy statement revised 12/2018 in part said, A comprehensive person-centered care place that include measurable objective and timetable to meet the resident physical, psychosocial and functional needs is developed and implemented for each resident 26867

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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** 16352 Based on observation, interview and record review the facility failed to ensure residents who was incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents reviewed for incontinent care (Resident #7) in that: The facility failed to ensure: -CNA -C practiced proper technique while providing incontinent care/ urinary catheter care for Resident #7. -Resident #7's catheter tubing was secured to his thigh. This failure could place residents with indwelling catheters at increased risk for urinary tract infections and potentially lead to urosepsis Findings include: Resident #7 Record review of the admission sheet for Resident #7 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension, (high blood pressure), cerebral vascular accident (stroke), recurrent urinary tract infection, trans metatarsal (limbs) amputation, peripheral vascular disease (poor blood flow to extremities), diabetic mellitus (high blood glucose) , hyperlipidemia (high cholesterol), sepsis (infection)with acute hypoxia (low oxygen), acute kidney injury , morbid obesity (very fat) due to excess calories . Record review of Resident #7's MDS dated [DATE] revealed a BIMS score of 15 indicating cognition intact. Further review revealed that Resident #7 required extensive assistance in the following areas: bed mobility, dressing, and personal hygiene. Further review revealed that Resident #7 required total assistance with toilet use and was always incontinent of bowel and bladder Record review of Resident #7's clinical physician orders dated 06/21/2021 revealed orders for Resident #7 to have a Foley 16 Fr. (French) catheter with a 10 cc (cubic centimeters) bulb (used to hold the catheter in place) and to change out every month and as necessary Record review of Resident #7's care plan initiated 06/21/2021 and revised 09/24/2021 revealed the resident was care planned for an indwelling urinary catheter related to a wound with the following interventions; monitor for signs and symptoms of Urinary Tract Infection: pain, burning, blood tinged urine, cloudiness, no output. Further interventions included providing catheter cleansing and perineal hygiene every shift and PRN if soiled. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of incontinent/indwelling catheter care for Resident #7 on 9/22/21 at 10:49 AM, CNA C entered the room with gloved hands, she repositioned the resident then went to a clean linen cart parked outside Resident #7's room and picked up wash cloths with the same gloves . At 11:03 AM CNA C opened up Resident #7's cover linen, the indwelling catheter was not secured to the thigh, tubing was tucked under the residents left thigh, she picked up the indwelling catheter and placed on the bed with 300 mls of yellow urine. CNA C used a wet wash cloth to clean the groin, perineal area and then cleaned the indwelling catheter. Resident #7 said I have been lying on the tubing and it hurts. When the tubing is under my foot it hurts and pains, until they change it. Resident #7 said he was repositioned from side to side every two to three hours. CNA C used the same gloves throughout the procedure. At 11: 09 AM CNA C left the room took off the dirty gloves without washing hands or using hand sanitizer opened the door to get more gloves, without washing hands or using hand sanitizer, she put on clean gloves. Interview with CNA C on 9/22/21 at 11:36 AM, she said she had been working at facility for 2 months, on the 6:00 AM to 2:00 PM shift. CNA C said she had 2 days of training and worked with the lead aide for 2 days and was left to work on the floor on her own. She said she forgot to wash her hands or use hand sanitizer, and did not know that an indwelling catheter bag with 300cc urine should not be on the bed. She said she knew indwelling catheter supposed to be secured and the nurses takes care of it. Interview on 09/24/21 at 4:15 PM with the DON, she said she had not done any in-services for the staff, she said CNA C just started working at the facility. The DON said she was going to start doing in-services now. The DON said the charge nurses were supposed to check the indwelling catheter straps were secured every shift and document to avoid tension, the CNAs are to report to the charge nurse if the straps to the catheter tubing was missing. The DON said the clinical educator no longer worked for the facility and she was in the process of hiring a new clinical educator. The DON did not find the check-off list for indwelling catheter care. The DON said they were going to retrain all staff. The DON presented individual incontinent check list in-services for CNA C on 9/29/21 at 4:00 PM. The DON further stated that she expected all indwelling catheter to be secured, positioned below bladder to prevent back flow of urine to the bladder causing infection and expected the staffs change gloves and washed hands when going from dirty to a clean area Record review of facility's policy for Indwelling Catheter Care (Daily Cleansing), [NAME]-Communities, dated 4/2011 revealed in part .Objective: Care and maintenance of indwelling catheters is essential to prevent infection and/or complications . Record review of facility's Checklist: Incontinent Care Procedure for Female/Male Resident, revised 4/17/2018 revealed in part .Procedure .If resident has an indwelling catheter, secure the tubing to the leg to avoid pulling

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review the facility failed to ensure residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 3 of 9 residents (Resident #297) reviewed for in house dialysis. The facility failed to have a system that ensured residents are assessed prior to admission to ensure dialysis offered at facility will meet their needs. The in-house dialysis machine was not capable of removing fluid from unstable dialysis for Resident #297 with end stage renal failure. The facility failed to establish an effective alternative way to dialyze Resident #297 when it was determined the in-house dialysis offered did not met the resident's dialysis needs. The facility failed to have systems in place where care provided to the residents through the dialysis contracted service was communicated to the facility and primary care physician to ensure continuation of care. The dialysis contractor did not follow physician's orders concerning obtaining labs, holding dialysis until lab results received and analyzed, notify the facility immediately when critical labs were reported. The facility failed to have a system in place to monitor the services provided by the in house contracted dialysis center. An Immediate Jeopardy (IJ) was identified on 9/25/21. While the IJ was removed on 9/27/21, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility continued to train staff and monitor the effectiveness of the Plan of Removal. This failure could place residents who received in house dialysis at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Resident #297 Record review of Resident #297's Admission Record dated 09/24/21 revealed she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included Hypertension, cerebral infarction, Acute respiratory failure, dependence on ventilator, Diabetic type 2, dependence on renal dialysis, end stage renal disease and major depression. Record review of Resident #297's Quarterly Minimum Data Set (MDS) assessment, dated 08/27/2021, revealed Resident #297 was severely cognitively impaired with a BIMS score of 0 and required total assistance from staff for bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/21/21 at 10:21 AM, Resident #297's family member said she felt like the dialysis company was not doing a good job with Resident #297's dialysis. She said the resident had hypotension(low blood pressure) when she went to dialysis her BP dropped and she was unable to complete dialysis and she felt like that had caused Resident #297to have a lot of fluids. She said that Resident #297 was on a medication to raise the blood pressure, but she did not know the name of the medication and the medication was PRN (As needed), but was changed to a scheduled dose. Resident #297's family member said she wanted the medication to be PRN as well so when Resident #297's blood pressure dropped; she can have the medication. She said she talked to the administrator and the DON and they said they were going to talk to the dialysis nurses. She said Resident #297 admitted with fluid to both arms, but it had gotten worse. She said she thought the dialysis nurses and the facility didn't care concerning Resident #297's dialysis and the fluids she had accumulated as a result of dialysis not pulling enough fluids off. During an observation on 09/21/21 at 10:30 AM, Resident #297 with tracheostomy, ventilator, feeding tube and 4+ edema to bilateral (both arms) upper extremities. Record review of Resident #297's physician orders revealed she had an order for midodrine 10mg (1) tablet via feeding tube every 8 hours for hypotension. Record review of nurse notes dated 08/08/21,08/23/21, 09/04/21,09/13/21 and 09/14/21 revealed Resident #297 had +3 edema and +4 documented on 07/23/21. Record review of Resident #297's care plan dated 00/00/00 revealed that the centered care was not addressing midodrine 10mg (1) tablet via feeding tube every 8 hours for hypotension and the 3+ edema. Further review revealed Resident #297 needs dialysis related to end stage renal disease goal to have no sign and symptoms of complication from dialysis, interventions to monitor input and output, monitor labs and report to physicians as needed. During an interview on 09/22/21 at 01:38 PM, the primary physician for Resident #297 said he was aware of the edema to the upper extremities and he ordered Dopplers last week not sure about the date. He said on 09/21/21 at night he received a call that Resident #297 was not doing well so they ordered to send her out for fluid overload. He said he was not sure why Resident #297 received dialysis 5 times per day it was the nephrologist that ordered it. He said that he was not sure if labs were ordered but his nurse practitioner will be able to answer the questions. During an interview on 09/22/21 at 03:07 PM, the NP said she was aware of Resident #297's edema and the difficulty with dialysis. She said she was notified and told that the dialysis machine did not pull fluids they only clean up creatinine. She said she found out about this on 09/20/21 when she saw Resident #297's edema had gotten worse and she went to the dialysis center and the dialysis nurse told her that the machine was not pulling the required fluid from Resident #297. The NP said that they would not take her to another dialysis centers because she was a ventilator resident. She said she talked to Resident #297's daughter about discharge to another facility after finding out about the machine, but the resident became critical and the night of 09/21/21 and was sent to the hospital for fluid overload. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/23/21 at 09:01 AM, RN dialysis nurse for dialyze direct in-house dialysis, she said that they had 8 residents on the in -house dialysis and they had dialysis five times per week. She said the residents had dialysis five times a week because the dialysis machine they were using was a home dialysis machine that usually was used for stable patients who can walk and had less fluids, and that had been part of problem for Resident #297. She said Resident#297 was not stable, and the machines were meant for more stable patients. She said the machine pulled the fluids slowly and do not pull enough fluids from Resident #297 because of her unstable condition and somedays her blood pressure would drop, and they had to hold dialysis. She said she did not assess the resident before admission to the - in house dialysis the intake department for the company evaluated the residents for admissions. She said she reported to the NP , neurologist, and the DON that Resident #297 was not suitable for the dialysis machine and they had been failing to remove the required 5 liters of fluids they would only remove 1.5 liter and some days no fluid. She said the NP,, neurologist and the DON said they should continue to see if the machine would remove more fluids, but they did not suggest sending the resident to the hospital. She said the machine was not appropriate for the Resident#297 because of her unstable condition, she said the facility and dialysis company was accepting residents that are critical and with edema, low blood pressure and they were not suitable for the in-house dialysis .She said that Dialysis communication sheet was the facility's responsibility to fill the pre and dialysis filled out the post dialysis portion and they have been instructed to leave them in the dialysis room and the unit manager picked them up. She said that she had not conducted any training with the nursing staff. She said that she would not recommend for residents that are not stable to use the dialysis machine they had because it was not for unstable patients. She said that when she observed something that is not normal in residents at dialysis, she alerted the facility, the company NP, and the dialysis NP would notify the nephrologist. During an interview on 09/23/21 at 09:36 AM, LVN dialysis nurse, with the dialysis company said she had been working for the dialysis center in the facility for three months but had 9 years' experience in dialysis. , She said Resident #297 was not stable enough and the dialysis center did not have the medications and the equipment required to pull the fluids, she said on multiple occasions she needed the nurses to notify the primary physician to send Resident #297 out but when she came back the next day the resident was still in the facility. She said that Resident #297 had fluid overload and they recommended that the facility call their physician to send her out. She said they were unable to pull a lot of fluids from Resident #297 because of the machines and the system they had in place. She said she had notified the nursing staff and the facility about Resident #297's fluids were not pulled out during dialysis and notified them also about the episodes of low blood pressure during dialysis. She said this problem had been going on about two months and she reported to the RN dialysis charge nurse who reported to the facility. During an interview on 09/23/21 at 10:00 AM, RN dialysis nurse, said Resident #297 was not getting enough fluids pulled out and the DON was notified. She said she was the one responsible to communicate with the facility when there was new recommendations from the dialysis NP or nephrologist and when the dialysis staff had information about residents that they needed the facility to be aware. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/23/21 at 10:31 AM, the NP for the dialysis company said she saw the residents once per month, but the dialysis nurse would communicate with her via phone if there were any changes in residents from her last visit. She said when hemoglobin levels drop below 7 their policy was to repeat the labs and if the results indicated low level, they recommended to send residents out to the hospital for transfusion. She said when the RN dialysis nurse reported recommendation to the facility to send the residents out, the facility did not send them out. She said that she knew that the dialysis machine pulled very little fluids and they were having a hard time pulling fluids from Resident#297 she needed to be sent back to the hospital. She said to be honest she does not know why Resident #297 was admitted to the facility because she was not stable and not appropriate for in- house dialysis machine at the facility. She said that the nephrologist was aware of the machine and the condition of Resident #297. She said that when she notified the physician about the machine and that it would only take out 2 liters or less instead of 5 liters because Resident# 297 was not stable, she said the physician said to try to pull whatever fluids they would pull and hold dialysis if the blood pressure dropped. During an interview on 09/24/21 at 12:00 PM, the ADON said the RN dialysis nurse communicated to her if the unit manager is not available, she communicated with the charge nurses working on the halls. She said that when she got the information from the RN dialysis nurse, she gave the information to the charge nurses if it was not critical information. She said that when information communicated to her by the RN dialysis nurse was critical, she would notify the physicians. The ADON said she talked Resident #297's daughter but did not remember the date, she said she was complaining that the dialysis center was not pulling out enough fluids. She said that she went to the room assessed the resident and she did not have a lot of fluid., she said she did not document her findings but she noticed that the resident had edema to the bilateral upper extremities and not the lower extremities. She said she did not notify the primary physician about Resident #297's concerns because the physician was aware of the edema. During an interview on 09/24/2021 at 12:15 PM, the DON said she reviews referrals but when they are dialysis the clinicals are sent to the dialysis company and the nephrologist will approve the clinicals. She said they started in -house dialysis on 08/01/21 and the company approved the clinicals and notified the facility to admit the residents. She said the medications that residents receive at dialysis they have a communication sheet they use to communicate with the dialysis center, but she had not followed up and she did not know if medications were administered in dialysis. She said that she did not know that the medication administered at dialysis was supposed to be on resident medication profile or care plan. She said that she was not aware that the dialysis machine was not pulling required fluid from Resident #297. She said the dialysis staff and daughter did not notify her about the machine not pulling enough fluids. She said that it was her responsibly to follow up with the nurses, unit manager and the dialysis nurse in regarding the dialysis treatment and update. She said she did not follow up with the nurses and the unit managers and moving forward she was going to put in place a new way to communicate to the dialysis staff and following up with the charge nurses and the unit manager. During an interview on 9/24/21 at 9:10 AM, the Administrator reported he and the DON are responsible for requesting and monitoring labs for residents that receive dialysis within facility dialysis center. [NAME] reports: in facility dialysis center has a different process and the in-facility dialysis center's lab company is Ascend Clinical, will draw routine labs but not sure of the process. [NAME] lab company comes when [NAME] calls for lab draws. [NAME] reports he does not know how critical labs are monitored and directed investigator to director of nurses. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/27/21 at11:45 AM, the Dialysis RN with DCD, reported she gave lab dated 9/8/21 with critical Hgb for Resident #61 to LPN B (primary care nurse) and informed her verbally that lab for Hgb needed to be redrawn prior to next dialysis day. Per in house dialysis policy Hgb will be above 7 g/dL. Dialysis RN produced document from her computer with lab results and that Hgb needed to be redrawn. During an interview on 9/27/21 at 12:30 PM, LPN B was asked if she received lab request from the dialysis RN, she was not able to remember ever receiving labs from the dialysis center or any verbal request for drawing Hgb lab. She reported she did not call the MD for any orders as she had not been notified of need. A review of the facility policy titled, Lab and Diagnostic Test Results-Clinical Protocol, last revised November 2018, revealed, The center is responsible for the timeliness of the services. The Director of Nursing (DON)/designee will be responsible for requesting lab orders when there is a need based on resident's diagnostic and monitoring needs and will process test requisitions and arrange for tests. The DON/designee will be responsible to notify the MD when a lab result is not received in a timely manner. Record review of the facility Renal Dialysis Affiliation Agreement dated 6/1/21 . 1. Initiation of Services. A. The Long Term Care (LTC) facility shall notify the dialysis facility when a Resident requires Renal dialysis and submit information to the dialysis facility regarding the resident as requested by the dialysis facility. B. The Dialysis Facility shall accept medically stable Residents into its home renal dialysis program, within the limit of its programs and facilities. Each such Resident accepted into the Dialysis Facility's home hemodialysis program is referred to herein as a Dialysis Resident, and collectively as, the Dialysis Resident. The Dialysis Facility reserves the right to refuse treatment to any Resident of the long term care facility that does not meet its admission criteria. At a minimum, in order for a Resident of the LTC facility to be accepted into the dialysis facility's home hemodialysis program, such resident must have a prescription for home hemodialysis written by a physician who has either temporary or permanent clinical privileges at the Dialysis Facility . 8. Education. The LTC facility shall make staff available to receive education from Dialysis Facility involved in caring for Dialysis Residents in the following areas to assure the LTC facility staff's ability to perform interventions for dialysis Residents when necessary: A. Monitoring of fluid gain and loss, including assessment of weight, blood pressure, pulse, respirations and intake and output. B. Assessment of laboratory values such as: BUN, serum creatinine, sodium, potassium, calcium, magnesium, phosphate levels, white blood count, hemoglobin and hematocrit. The facility Administrator was informed that an Immediate Jeopardy (IJ) was identified on 9/25/21 at 12:23 pm . IJ template was provided and plan of removal was requested. (continued on next page)

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	455815	A. Building B. Wing	09/29/2021

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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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Plan of Removal was submitted and was accepted on 9/27/21 at 4:15 PM after several revisions. The plan of removal included the following: Resident #296 is no longer in the facility. On 9/24/2021, the DON (director of nursing) completed an audit of all laboratory orders and most recent laboratory results of the eight (8) residents on hemodialysis. The audit was completed after the IJ was called. The results of the audit were documented on the QI tools titled, Dialysis Communication Audit Tool. There was no concern identified. The audits were completed before midnight on 9/24/2021. Ad-Hoc QAPI meeting was held on 9/24/2021, with the Medical Director, NHA (Nursing Home Administrator), VP of Patient Services from dialysis company and DON to review the alleged deficiencies, policy and procedure, and the plan for removal of immediacy. Another Ad-Hoc QAPI meeting was held on 9/25/2021, with the Medical Director, NHA (Nursing Home Administrator), VP of Patient Services from dialysis company and DON to review the alleged deficiencies, policy and procedure, and the plan for removal of immediacy. Starting on 9/25/2021, the facility leadership (Administrator, DON and Unit managers) will have a weekly call to discuss the overall dialysis program with the contracted dialysis company and review the specific services provided for each resident who requires dialysis treatments, to ensure that each resident receives the services consistent with the professional standards of practice, comprehensive person-centered care plan and the residents' goals and preferences. Meetings will start the week of 27 Sept - 1 [DATE]. These meetings are in addition to the daily handoff with facility clinical staff. The discussion will include but not limited to alternate way to dialyze residents whose dialysis needs cannot be met by the in-house dialysis program. Any concern identified during the weekly call will be reported to the nephrologist and/or medical director for further discussion. The facility will continue to have the dialysis staff review referral for potential admissions. Dialyze Direct Intake Department will review patients to ensure they can meet their needs. No resident will be admitted for in-house dialysis without their approval. DON/designee will review clinical paperwork to ensure facility can meet their needs. The policy pertaining to hemodialysis was reviewed on 9/24/2021 by the DON, NHA (Nursing Home Administrator) and Medical Director. The policy includes, but not limited to compliance guidelines related to ongoing communication and collaboration of the dialysis unit staff and the nurses in the unit. The Administrator will be responsible to ensure this plan is completed on 9/28/2021. The surveyors monitored the Plan to lower the Immediately Jeopardy as follows: Record review of the facility roster dated 9/24/21 revealed the DON completed an audit of all residents to verify change in conditions were identified and proper assessments were completed. The form revealed there was no findings of change in conditions not identified. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's in - services dated 9/24/21 through 9/28/21 revealed facility nursing staff were in - serviced over procedure for change in condition. The DON (director of nursing) completed an audit of all laboratory orders and most recent laboratory results of the eight (8) residents on hemodialysis. The audit was completed after the IJ was called. The results of the audit were documented on the QI tools titled, Dialysis Communication Audit Tool. There was no concern identified. The audits were completed before midnight on 9/28/2021. Interviews were conducted on 9/25/21 and 9/26/21 with weekend staff members that included LVN's, and RT's. On 9/25/21 starting at 1:42 PM, 2 morning shift (6am - 2pm) and 9/26/21 evening shift (2pm -10pm) LVN's were interviewed change in condition, obtaining laboratory test, documenting, reporting results to doctor of the eight (4) residents on in house hemodialysis. On 9/27/21 starting at 10:42 AM 2 day shift nurses (7am - 7pm) were interviewed and on 9/27/21 1 night shift (7pm - 7am) nurse was interviewed regarding what was considered a change in condition, obtaining laboratory test, documenting, reporting results to doctor of the residents. All staff members interviewed were able to voice knowledge over in - service areas and provided acceptable answers to interview questions. Interview with facility Administrator on 09/28/21 at 4:00pm, the facility Administrator said the facility should have done a proper follow up with residents on in house dialysis with the dialysis company. He said a new form indicating what went on at dialysis had been developed and is being implemented. He said starting from 09/28/21, there will be a weekly meeting with the facility staff and the dialysis staff to discuss all resident's on inhouse dialysis and their progress. He said the IJ incident occurred due to lack of proper communication between the dialysis company and facility staff. He said all nursing personnel would be trained on assessing all resident' before and after dialysis that includes, weights, vital signs, dialysis shunt, and what medication was given pre and post dialysis as well as monitoring resident's intakes. Record review of facility monitoring tool started on 9/28/21 revealed the DON was monitoring what residents had a change in condition, laboratory services order and result of any critical labs what the change was and when it was noted, if the MD/NP was notified, if there was orders given and were they carried out and whether there was any concern identified with the procedure for the particular change in condition. Record review of facility monitoring tool started on 9/27/21 revealed DON was monitoring 24-hour reports and whether nursing staff were reporting and identifying change in conditions on the report and if nursing staff had communicated and followed up on changes on the next shift. The Administrator and DON were notified the IJ was removed on 9/27/21 at 4:15 PM. However, the facility remained out of compliance at a severity of level of actual harm that is not immediate jeopardy and a scope of pattern due to the facility needing more time to monitor the plan of correction effectiveness. 44130 44591

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 26867 Based on observation, record review and interview, the facility failed to post the daily nurse staffing data at the beginning of each shift in a prominent place, readily accessible to residents and visitors that included the facility name, resident census, the total number of hours worked per shift by the registered nurses, the licensed vocational nurses, and the certified nurse aides directly responsible for resident care at the facility for 3 days (.9/21/21, 9/22/21 and 9/26/21) reviewed for nurse staffing. The facility did not post the required staffing with hours worked daily and resident census on 9/21/21, 9/22/21 and 9/26/21. This deficient practice could place the residents, families, and visitors at risk of not having access to information regarding the daily nurse staffing data. Findings included: Observation on 09/21/21 from 9AM to 4:30PM, pm revealed no daily staffing information. Observation on 09/22/21 from 8:30AM to 11:20PM, revealed no posted daily staffing information. During an interview on 09/22/21 at 10:30AM, the DON said it was posted by the time clock. She showed the staffing sign in sheet. Further interview she said she would ask the staffing coordinator. During In an interview with the Administrator about the staffing data, he said he would ask the DON. During In an interview on 09/22/21 at 12:00PM, the administrator said it w as posted behind the ombudsman's information. During an linterview with the staffing coordinator on 09/22/21 at 1:0PM, she said the receptionist at the front desk was responsible for posting the staffing schedule after she verified the schedule. During an linterview with the receptionist in 09/23/21 at 1:30PM, she said she had no knowledge about staffing data posting. Observation on 09/26/21 at 10:00AM, revealed the posted staffing data was dated 09/25/21. During In an interview with the DON on 09/26/21 at 11 :20AM, she took the posted staffing data dated for 09/25/21 out and said it was the wrong one. She said she would have the corrected one posted Record review of facility policy titled Posting direct care daily staffing numbers dated 2001 revised July 2016 read in part- (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	1 We will post the number of licensed Nurse (RN, LPN and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident's care will be posted in a prominent location and in a clear readable format.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34496 Based on observations, interviews, and record reviews the facility failed to ensure that drugs and biologicals were labeled in accordance with professional principles and in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls for 2 of the 4 medication carts (Hall 200 front nurse cart and Hall 300 MA cart) reviewed and 1 of the 2 me The facility failed to ensure: - the Hall 200 front nurse's medication cart did not contain 5 open Insulin pens for different residents without opening dates. , So as to know the dates when to discard them a per manufacturer's recommendations. - the Hall 300 Medication Aide's cart 1 did not contain an ophthalmic solution (Latonoprost) with opening date of 4 months back ([DATE]) - Recommendations from facility's pharmacy indicating to be discarded after 6 weeks of opening date). - the Hall 200 medication room did not contain 5 premixed Intravenous Tobramycin bags lying on counter topcountertop at room temperature, the label showing To be Refrigerated. These failures could place residents at risk of not receiving the optimum therapeutic benefits of the medications and have adverse reactions to medications. Findings Include: Observation of the hall 200 front nurse medication cart on [DATE] at 1:30 PM, revealed 5 insulin pens (3 Insulin Basglar/Lantus, 1 Levamir, 1 Humalog, and 1 Insulin Aspart for different residents, opened but without opening dates on them . The insulin pens without opening dates were shown to DON present there and she said, they all should be dated on opening so they can be discarded after their recommended duration to be used after opening dates as they might loose their efficacy after that duration. Observation of the 200 hall medication room on [DATE] at 1:45 PM, revealed 5 bags of intravenous antibiotic Tobramycin premixed bags lying on the counter topcountertop, (labels on the bags indicate saying To be Refrigerated . The bags were delivered by pharmacy on [DATE] as per the label on the bags. The LPN D present in the medication room was shown the bags and said that the nurse who received them should have kept them in the refrigerator as per the instructions on the label and the antibiotic might loose efficacy or have adverse reaction on use if not stored as per instructions on the label. She said that she does not know for how long the antibiotics bags have been out of refrigerator. She said those bags will be handed over to the DON and will be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the 300 hall medication aide's cart on [DATE] at 2:15 PM, revealed 1 bottle of Latanoprost ophthalmic solution (used to treat increased pressure inside the eyes called Glaucoma, with openinging date of [DATE], (Storage Recommendation from Facility's Pharmacy reads once bottle is opened for use, it may be stored at room temperturetemperature for 6 weeks). The LVN E holding the keys to the cart said that the eye drops if used after the recommended use duration after opening date can cause harm or might not have full benefit of use. Interview with DON of the facility on [DATE] at 8:45 AM, the DON revealed that the nurses are educated for and supposed to put the opening dates on all medications including Insulin pens and eye drops because the medications would loose efficacy after the recommended period or might have an adverse effect She said the nurses are supposed to check their carts forcarts for expired/beyond use date on all medications every shift and before use. She further said that the unit managers check the medication carts and medication rooms randomly every week and the pharmacist comes and checks them every month. She said it's the nurse's responsibility to store those medications in the refrigerator which are recommended by pharmacy to be stored refrigerated. She said those antibiotic bags and undated insulins were discarded and replacements were ordered for them. Interview with ADON/Unit Manage D on [DATE] at 8:30 AM, the ADON/Unit Manager D revealed that the nurses who receive the medications from pharmacy are responsible to store them in the refrigerator if recommended by the pharmacy. He said he and the other unit manager audit the medication carts and medication rooms randomly every week for expired/ beyond use dates and the pharmacist comes to the building and audits them every month. Record Review of the facility's medication storage policy (revised April,2007) revealed: The facility shall not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Medications requiring refrigeration must be stored in a refrigerator located in drug room at the nurses' station.

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation , interview and record review, the facility failed to obtained laboratory services as ordered by the physician and report results in accordance with facility policy and procedures for notification for 3 of 3 residents (Resident #47, #296, #61) reviewed for notification of lab results. The facility failed to recheck Hgb level for Resident #47, #296 and #61 as ordered by the NP when previous Hgb lab values for all three dialysis residents were low/abnormal. Following Surveyors intervention, Resident #47, #296 and #61 were transported to the hospital for evaluation of their critical Hgb labs values which were confirmed to be low at the hospital. Resident #47, and #61 remained hospitalized until survey exit while #296 returned to the facility. An Immediate Jeopardy (IJ) was identified on 9/24/21. While the IJ was removed on 9/27/21, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility continued to train staff and monitor the effectiveness of the Plan of Removal. These deficient practices could place residents at risk of decline in health from not having their laboratories identified and addressed promptly. Resident #47 Review of Resident #47's MDS assessment, dated 08/12/21, reflected she was admitted to the facility on [DATE] readmitted , was a [AGE] year-old female, was severely cognitively impaired, and her diagnoses included, chronic respiratory failure with hypoxia (low oxygen), pneumonia, pressure ulcer of sacral region (wound to lower tail bone), unspecified stage, major depressive disorder, recurrent severe without psychotic, pneumocystis (attacks especially to lung tissues characterized by nonproductive cough, shortness of breath and fever), other lack of coordination, and end-stage renal disease. Review of progress note written NP A b y for Resident #47, dated 09/23/21, reflected the following, resident goes to dialysis Monday, Tuesday, Wednesday, Thursday, Friday in house dialysis. Record review of laboratory (Lab) results dated 9/8/21 indicated Resident #47's hemoglobin (Hgb) was 6.6 g /dl (normal range 12.9 -16.0 g/dl,) which was (critical), there was no documentation that the M.D/NP was notified. During an with Interview with the NP on 9/23/21 at 12:30 PM, she said she told the dialysis nurse (RN AA) and the DON about the critical lab and wanted it repeated before Resident #47 was dialyzed. There was were no documentation that dialysis was held, and lab was repeated from 9/9/21 till today (9/23/21) and Resident #47's Hgb was 5.5 m/dl, (Critical), and Resident #47 was transferred to hospital due to the critical labs. NP said she gave a verbal order on 9/9/21 for dialysis to be held and lab repeated. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with RN AA on 9/23/21 at 3:55 PM , she confirmed that Resident # 47 with low Hgb was were being dialyzed Monday through Friday. RN AA said the facility DON knew about the low Hgb and Resident #47's needed the Hgb repeated before being dialyzed. RN AA said she did not check for the lab before dialyzing Resident #47 on from 9/9/21, 9/10/21, 9/13/21, 9/14/21, 9/15/21, 9/16/21, 9/17/21, 9/20/21, 9/21/21, 9/22/21 and 9/23/21 (11 days). During an interview with the DON on 9/23/21 at 4:20 PM, regarding repeating critical Hgb of (6.6 mg/dl) for Resident #47 on 9/8/21. She DON said she was not aware of the lab order and RN AA did not bring it to her attention. Record review of a Resident #47's hospital ER assessment on 9/23/21 at 5:00 PM and lab for Resident #47 revealed the Hgb was 5.6 g/dl (LL) =(normal range12.0-16.0g/dl) and the HCT 18.2 (Hematocrit) (Low) (range with 37-47%). Resident #47 was still in the hospital on 9/29/21. Resident #296 Record review of Resident # 296 Admission Record dated 09/24/21 revealed Resident #296 was [AGE] years-old and was admitted to the facility on [DATE]. Resident #296's diagnoses included tracheostomy status, Acute respiratory failure, major depression, dependence on ventilator, Diabetic type 2, and dependence on renal dialysis. Record review of Resident #296's Admission Minimum Data Set (MDS) assessment, dated 07/26/2021, revealed Resident #296 was severely cognitively impaired with a BIMS score of 0 and required extensive assistance from staff for bed mobility, and total dependence with dressing, toilet use, and personal hygiene. Observation on 09/21/21 at 10:10 AM, Resident #296's room the resident was out for dialysis, feeding tube formula was on the table, canister on the bedside table had bloody secretions' that was suctioned from resident. Record review of Resident #296's physician orders revealed that Resident #296 had a tracheostomy, feeding tube and was on dialysis 5 times per week. Further review of Resident #296's physician orders revealed order for medication of Eliquis 2.5mg daily via G- Tube. Record review of Resident #296's care plan dated 07/22/21 and was not revised with the resident medication Eliquis 2.5gm and the bleeding condition during suctioning. During an interview with the respiratory therapy director on 09/22/21 at 12:00 PM, he said that he had 12 staff under his supervision that work 12-hour shifts. He said that he was aware of Resident #296's bloody secretions and he notified the nurses but did not notify the physician. He said he does not know the cause of the bleeding but in most cases it's because of suctioning too much, not having enough humidity or positioning. He said that Resident #296 may need to have a scope to be able to know what was causing the bleeding and he had not been seen by a pulmonologist for the bleeding. He said that the resident had the episodes of bloody secretions during suctioning on and off since admission to the facility (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of labs hematology collected on 09/07/21 and received on 09/08/21 results indicated the hemoglobin of 6.6 normal range was indicated as 13.7 -17.5. Another hematology collected on 09/09/21 and received on 09/09/21 results indicated hemoglobin of 7.8. Hematology collected on 09/21/21 results received on 09/23/21 hemoglobin results indicated 6.9. During an interview with RN dialysis nurse dialyze direct in-house dialysis on 9/23/21 at 9:01 PM, she said that they had 8 residents on the in -house dialysis and they had dialysis five times per week. She said that the residents they had dialysis five times a week because the dialysis machine they were using was a home dialysis machines that usually were used for stable patients who can walk and had less fluids. She said that Dialysis communication sheet was facility's responsibility to fill the pre and the dialysis filled out the post dialysis portion and they have been instructed to leave them in the dialysis room and the unit manager picked them up. She said that she has not conducted any training with the nursing staff. She said that she would not recommend for residents that are not stable to use the dialysis machine that they had because it not for unstable patients. She said that when she observed something that is not normal in residents at dialysis, she alerted the facility, the company nurse practitioner, and the dialysis nurse practitioner would notify the nephrologist. she reports she gave lab results for Resident #296 dated 9/8/21 with critical Hgb to ADON B and informed her verbally that lab for Hgb needed to be redrawn prior to next dialysis day. She said she never heard from the ADON B with the results, so they contained the next day to dialyze Residents #296. She said that the policy in the dialysis center is when the hemoglobin is less 7, they order a repeat lad and hold dialysis until they get the results. She said that she continued to dialysis for Resident #296 because she never heard back from ADON B and she never followed up with her to see if the results were received. She said that on 09/21/21 the dialysis nurse practitioner ordered hematology lab again and the results indicated that hemoglobin was 6.9 and the dialysis nurse practitioner recommended for Residents#296 to be sent out to the hospital. Interview with the nurse practitioner for the dialysis company on 9/23/21 at 10:31 AM, she said she saw the residents once per month, but the dialysis nurse would communicate with her via phone if there were any changes in residents from her last visit. she said that when hemoglobin levels drop below 7 their policy was to repeat the labs and if the results indicated low level, they recommended to send residents out to the hospital for transfusion. She said that when the RN dialysis nurse reported recommendation to the facility to repeat the lab the facility did not repeat the labs and or communicate back with dialysis that is why she ordered more lab on 09/21/21 for Resident #296 and the results on 09/23/21 were hemoglobin 6.9 and she recommended for Resident # 296 to be sent out to the hospital. Interview on 09/24/21 at 12:00 PM, the ADON said that the RN dialysis nurse communicated to her and if the unit manager is not available, she communicated with the charge nurses working on the halls. She said that when she got the information from the RN dialysis nurse, she gave the information to the charge nurses if it was not critical information. She said that when what they communicated to her by the RN dialysis nurse was critical, she would notify the physicians. She said that when the lab results were received on 09/08/21 they repeated the lab on 09/09/21 the results were still low but she did not communicate with dialysis RN to let her know about the results and she does not know if the floor nurse communicated the results. She said that the correct procedure was to report the results to dialysis nurse so that they knew what the repeat lab results were. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 09/24/2021 at 12:15 PM, the DON she said that she reviews referrals but when they are dialysis the clinicals are sent to the dialysis company and the nephrologist will approve the clinicals. She said that they started in -house dialysis on 08/01/21 and the company approved the clinicals and notified the facility to admit the residents. She said the medication that residents receive at dialysis they have a communication sheet that they use to communicate with the dialysis center, but she had not followed up and she did not know if medications were administered in dialysis. She said that she did not know that the medication administered at dialysis was supposed to be on the resident medication profile or the care plan. She said that it was her responsibly to follow up with the nurses, unit managers and the dialysis nurse regarding the dialysis treatment and update. She said she was aware of the low hemoglobin for Resident #296, but she was not sure if the nurses repeated the labs and reported back to dialysis. She said she did not follow up with the nurses and the unit manages and moving forward she was going to put in place a new way to communicate to the dialysis staff and following up with the charge nurses and the unit managers. She said that she knew that the results received on 09/23/21 were low and Resident #296 was sent out to the hospital Resident #61 Record review, to include physician orders, laboratory reports and Minimum Data Set (MDS) revealed the facility admitted Resident #61 on 06/23/2021 with diagnoses which included End Stage Renal Disease (kidneys are no longer able to work as they should to meet your body's needs), Acute and Chronic Respiratory Failure with Hypoxia (abnormal functioning of the lungs with decreased ability utilize adequate oxygen supply at the tissue level), Anoxic Brain Damage (harm to the brain due to a lack of oxygen), history of Cardiac Arrest (a condition where the heart suddenly stops beating, which results from the problem in the electrical disturbance). A review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed Resident #4 's BIMS score as 0, which indicated the resident was not able to be interviewed. A further review of the MDS revealed the facility assessed Resident #61 as needing dialysis five (5) out of five (5) days a week during the assessment period. A review of Resident #61's computerized physician orders (CPO) revealed no order for labs drawn on 09/07/2021 with reported Hemoglobin (Hgb)=4.6g/dL Normal range 11.2-15.7g/dL. A record review of the Medical Administration Record (MAR) dated 09/24/2021 revealed the dialysis facility gave dialysis on 09/08/2021, then resident sent to hospital on 09/09/2021. A review of Resident #61's computerized physician orders (CPO) dated 00/00/00 revealed the resident had orders for Complete Blood Count (CBC), Basic Metabolic Panel (BMP) and STAT CBC on 09/23/2021, no record of lab being obtained was noted on the chart. A review of the Minimum Data Set (MDS) record revealed on 9/9/21 eINTERACT in PointClick Care (PCC) shows Transfer form V4.1 for discharge to hospital. On 9/7/21 Resident #61 had a hemoglobin level of 6.9 and was sent out to the hospital on 9/21/21 with a hemoglobin level of 6.7 following surveyor intervention. The facility failed to follow physician order, requesting lab orders that were need based on resident's diagnostic and monitoring needs and processing test requisitions and arrange for tests due to low hemoglobin found by in facility dialysis laboratory results (continued on next page)

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	455815	A. Building B. Wing	09/29/2021

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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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/24/21 at 9:10 AM, the Administrator reported he and the DON are responsible for requesting and monitoring labs for residents that receive dialysis within facility dialysis center. [NAME] reports: in facility dialysis center has a different process and the in-facility dialysis center's lab company is Ascend Clinical, will draw routine labs but not sure of the process. [NAME] lab company comes when [NAME] calls for lab draws. [NAME] reports he does not know how critical labs are monitored and directed investigator to director of nurses. During an interview on 9/27/21 at11:45 AM, the Dialysis RN with DCD, reported she gave lab dated 9/8/21 with critical Hgb for Resident #61 to LPN B (primary care nurse) and informed her verbally that lab for Hgb needed to be redrawn prior to next dialysis day. Per in house dialysis policy Hgb will be above 7 g/dL. Dialysis RN produced document from her computer with lab results and that Hgb needed to be redrawn. During an interview on 9/27/21 at 12:30 PM, LPN B was asked if she received lab request from the dialysis RN, she was not able to remember ever receiving labs from the dialysis center or any verbal request for drawing Hgb lab. She reported she did not call the MD for any orders as she had not been notified of need. A review of the facility policy titled, Lab and Diagnostic Test Results-Clinical Protocol, last revised November 2018, revealed, The center is responsible for the timeliness of the services. The Director of Nursing (DON)/designee will be responsible for requesting lab orders when there is a need based on resident's diagnostic and monitoring needs and will process test requisitions and arrange for tests. The DON/designee will be responsible to notify the MD when a lab result is not received in a timely manner. The facility Administrator was informed that an Immediate Jeopardy (IJ) was identified on 9/24/21 at 6:25pm. IJ template was provided and plan of removal was requested. A Plan of Removal was accepted on 9/27/21 at 4:15pm after several revisions. The plan of removal included the following: Resident #296 is no longer in the facility. Resident #47 and # 61 is no longer in the facility. Residents #296's heir attending physicians were notified of the alleged deficiency on 9/24/21. There was no new order obtained. On 9/24/2021, the DON (director of nursing) completed an audit of all laboratory orders and most recent laboratory results of the eight (8) residents on hemodialysis. The audit was completed after the IJ was called. The results of the audit were documented on the QI tools titled, Dialysis Communication Audit Tool. There was no concern identified. The audits were completed before midnight on 9/24/2021. Ad-Hoc QAPI meeting was held on 9/24/2021, with the Medical Director, NHA (Nursing Home Administrator), VP of Patient Services from dialysis company and DON to review the alleged deficiencies, policy and procedure, and the plan for removal of immediacy. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The policy pertaining to hemodialysis was reviewed on 9/24/2021 by the DON, NHA (Nursing Home Administrator) and Medical Director. The policy includes, but not limited to compliance guidelines related to ongoing communication and collaboration of the dialysis unit staff and the nurses in the unit. As of 9/24/2021, a new protocol was developed by the QAPI team related to the dialysis communication. Starting on 9/25/2021, the facility will use a revised dialysis communication form. The licensed nurse will complete the portion related to: Additional Information such as Changes in condition, physician order changes, new labs since last visit. Before the return of the resident to the unit after dialysis treatment, the dialysis nurse will complete the portion of the dialysis communication related to: Additional Information - Changes in condition, medications administered, labs drawn, lab results, and new MD Orders/Recommendations. In addition, the facility and dialysis staff will also conduct a dialysis huddle meeting during scheduled dialysis treatments. The meeting minutes will documented in the Dialysis Huddle Meeting Minutes form. The dialysis staff and facility clinical team will discuss items which will include but not limited to: i) changes in condition during dialysis, ii) new physician order changes, iii) new labs orders and iv) any recommendations from the dialysis staff. The facility will follow the Policy for Change of Condition. The facility will contact the primary care physicians, the families and the nephrologists. These communications will take place after facility has been notified of changes from dialysis. Licensed staff will complete change of condition in the EMR system. Care plan nurse will update the care plan. Nursing staff will carry out care plans. The clinical management team and dialysis staff will be trained by the DON/designee on the above-mentioned policies and procedures and revisions, focusing on communication to ensure labs are done timely as ordered. The training will also include but not limited to: providing or obtaining laboratory services to meet the needs of its residents, the staff's responsibility to ensure quality and timeliness of laboratory services and carrying out lab orders. The training was initiated on 9/24/2021 and will be completed on 9/25/2021. Clinical management team/dialysis staff will not be allowed to work until they receive the training. The DON will monitor compliance by completing audit of three (3) dialysis residents per week for four (4) weeks. This was initiated on 9/25/2021. Any identified concern will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance. The Administrator will be responsible to ensure this plan is completed on 9/29/2021. The surveyors monitored the Plan to lower the Immediately Jeopardy as follows: Record review of the facility roster dated 9/28/21 revealed the DON completed an audit of all residents to verify new laboratory dialysis were identified and proper assessments were completed. The form revealed there was no findings of change in conditions not identified. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with facility Administrator on 09/28/21 at 4:00pm, the facility Administrator said the facility should have done a proper follow up with residents on in house dialysis with the dialysis company. He said a new form indicating what went on at dialysis had been developed and is being implemented. He said starting from 09/28/21, there will be a weekly meeting with the facility staff and the dialysis staff to discuss all resident's on inhouse dialysis and their progress. He said the IJ incident occurred due to lack of proper communication between the dialysis company and facility staff. He said all nursing personnel would be trained on assessing all resident' before and after dialysis that includes, weights, vital signs, dialysis shunt, and what medication was given pre and post dialysis as well as monitoring resident's intakes. Record review of facility monitoring tool started on 9/28/21 revealed the DON was monitoring what residents had a change in condition, laboratory services order and result of any critical labs what the change was and when it was noted, if the MD/NP was notified, if there was orders given and were they carried out and whether there was any concern identified with the procedure for the particular change in condition. Record review of facility monitoring tool started on 9/27/21 revealed DON was monitoring 24-hour reports and whether nursing staff were reporting and identifying change in conditions on the report and if nursing staff had communicated and followed up on changes on the next shift. The Administrator and DON were notified the IJ was removed on 9/27/21 at 4:15 PM. However, the facility remained out of compliance at a severity of level of actual harm that is not immediate jeopardy and a scope of pattern due to the facility needing more time to monitor the plan of correction effectiveness. 44130 44591

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions in accordance with preferred standards for food safety in 1 of 1 kitchen reviewed for kitchen sanitation. - The facility failed to ensure: -all food items were labeled and dated. -expired foods were discarded. -equipment used daily were was kept clean. -the vent hood in the kitchen was were cleaned and maintained as scheduled. -accurate documentation of dishwashing machines' PPM (parts per million) . These deficient practices could place residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings include: Observations and interview with the DM of the kitchen on [DATE] from at 9:00AM to 9:20AM, revealed the following: - All unlabeled food items were identified by the DM (Dietary Manager) one commercial can opener in the kitchen was dirty, . It had a dark substances around the blade and the holder; cooler #2 Juice in a large container covered with a plastic wrap dated [DATE],. The DM took it out of the cooler and said this should not be there Pudding in a lager bowl covered with plastic wrap dated used by [DATE]; Sandwich wrapped with plastic wrap undated and unlabeled;. Spanish rice in a plastic bag dated used by [DATE] Beets in a large container covered with a plastic wrapped undated and unlabeled;. Left over chilies in a plastic bag undated and unlabeled (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Potato salad in a plastic container covered with plastic wrapped dated used by [DATE] Left over corn dogs in a plastic bag undated and unlabeled Freezer #2 had strawberries in a plastic bag unlabeled and undated. Observation of the dry storage goods on [DATE] at 9:22:0AM, revealed 9 boxes of 24oz baking soda dated used by June 30th 2020. Observation of the vent hood in the kitchen on [DATE] at 9:24 AM,revealed grease and dust build up. The last date on the vent hood for commercial cleaning was dated ,d+[DATE] next due date was marked as , d+[DATE]/, was left blank indicating the cleaning the cleaning of the vent hood was not done cleaned as scheduled. Interviewed with the DM on [DATE] at 9:25AM, She said the cleaning company did not come as scheduled but she would call the company to find out what happened. Observation and interview on [DATE] at 9:40AM, revealed the dishwashing PPM was reading 200 PPM (Parts per million). The DM said the dishwashing machine was a low temperature machine and should be reading between ,d+[DATE] PPM. She said she would call the company to adjust the PPM flow . Record review of posted log titled Chemical sanitizing dish [NAME] ,d+[DATE] to ,d+[DATE] -2021 revealed the PPM was documented as 100 PPM on all shifts shifts from [DATE] through [DATE]. During an interview with DA Z on [DATE] at 9:00AM, whose initials was on the log, looked at the log and said nothing. During an interview with the DM on [DATE] at 9:30AM, she said this was her second day working at the facility and she was in the process of cleaning up. She said all food out of original containers should be properly stored in an airtight container dated the date it was opened and used by date. She said she would have an in-service with all staff . Record review of the facility's policy titled, labeling and dating of product for storage undated read in part- Policy statement Food shall be received and stored in a manner that complies with safety food handling policies. # 8 All food stored in the refrigerator or freezer will be covered, labeled and dated used by date .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 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 diseases and infections for 1 of 4 residents (Resident #78) reviewed for infection control. The facility failed to ensure CNA C washed her hands or used alcohol-based hand sanitizer while performing incontinent care for Resident #7. This failure could place residents getting incontinent care at risk of infection through cross-contamination. Findings included: Resident #7 Record review of the admission sheet for Resident #7 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension, (high blood pressure), cerebral vascular accident (stroke), recurrent urinary tract infections, trans metatarsal (limbs) amputation, peripheral vascular disease , diabeties mellitus (high blood sugar) , hyperlipidemia (high, sepsis (infection)with acute hypoxia (low oxygen), acute kidney injury , morbid obesity (very fat) due to excess calories Record review of the admission sheet for Resident #7 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension, (high blood pressure), cerebral vascular accident (stroke), recurrent urinary tract infection, trans metatarsal (limbs) amputation, peripheral vascular disease (poor blood flow to extremities), diabetic mellitus (high blood glucose) , hyperlipidemia (high cholesterol), sepsis (infection)with acute hypoxia (low oxygen), acute kidney injury , morbid obesity (very fat) due to excess calories . Record review of Resident #7's MDS dated [DATE] revealed a BIMS score of 15 indicating cognition intact. Further review revealed that Resident #7 required extensive assistance in the following areas: bed mobility, dressing, and personal hygiene. Further review revealed that Resident #7 required total assistance with toilet use and was always incontinent of bowel and bladder. Record review of Resident #7's clinical physician orders dated 06/21/2021 revealed orders for Resident #7 to have a Foley 16 Fr. (French) catheter with a 10 cc (cubic centimeters) bulb (used to hold the catheter in place) and to change out every month and as necessary. Record review of Resident #7's care plan date initiated 06/21/2021 and revised 09/24/2021 revealed theat resident was being care planned for an indwelling urinary catheter related to a wound with the following interventions; monitor for signs and symptoms of Urinary e Tractk Infectiion: pain, burning, blood tinged urine, cloudiness, no output. Further interventions included providing catheter cleansing and perineal hygiene every shift and PRN if soiled (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of incontinent/indwelling catheter care for Resident #7 on 9/22/21 at 10:49 AM, CNA C entered the room with gloved hands, she repositioned the resident then went to a clean linen cart parked outside Resident #7's room and picked up wash cloths with the same gloves . At 11:03 AM CNA C opened up Resident #7's cover linen, the indwelling catheter was not secured to the thigh, tubing was tucked under the residents left thigh, she picked up the indwelling catheter and placed on the bed with 300 mls of yellow urine. CNA C used a wet wash cloth to clean the groin, perineal area and then cleaned the indwelling catheter . Resident #7 said I have been lying on the tubing and it hurts . When the tubing is under my foot it hurts and pains, until they change it . Resident #7 said he was repositioned from side to side every two to three hours. CNA C used the same gloves throughout the procedure. At 11: 09 AM CNA C left the room took off the dirty gloves without washing hands or using hand sanitizer opened the door to get more gloves, without washing hands or using hand sanitizer, she put on clean gloves. Interview with CNA C on 9/22/21 at 11:36 AM, she said she had been working at facility for 2 months, on the 6:00 AM to 2:00 PM shift. CNA C said she had 2 days of training and worked with the lead aide for 2 days and was left to work on the floor on her own. She said she forgot to wash her hands or use hand sanitizer, and did not know that an indwelling catheter bag with 300cc urine should not be on the bed . She said she knew indwelling catheter supposed to be secured and the nurses takes care of it. Interview on 09/24/21 at 4:15 PM with the DON, she said she had not done any in-services for the staff, she said CNA C just started working at the facility. The DON said she was going to start doing in-services now. The DON said the charge nurses were supposed to check the indwelling catheter straps were secured every shift and document to avoid tension, the CNAs are to report to the charge nurse if the straps to the catheter tubing was missing . The DON said the clinical educator no longer worked for the facility and she was in the process of hiring a new clinical educator. The DON did not find the check-off list for indwelling catheter care. The DON said they were going to retrain all staff. The DON presented individual incontinent check list in-services for CNA C on 9/29/21 at 4:00 PM. The DON further stated that she expected all indwelling catheter to be secured, positioned below bladder to prevent back flow of urine to the bladder causing infection and expected the staffs change gloves and washed hands when going from dirty to a clean area Observation of incontinent/indwelling catheterindwelling catheter care on 9/22/21 at 10:49 AM with CNA C. CNA C came in the room withroom with gloved hands, repositioned resident then went to a packed cleaned cart outside Resident #7's room and picked up wash cloths face towels. At 11:03 AM, CNA C open up Resident #7's cover linen , the indwelling catheter was not secured, tubing was [NAME] tucked under the residents left thigh, she picked up the indwelling catheter and placed on the bed with 300 mls of yellow urine. CNA C usedC used a wet wash cloth face towel to clean the groin, perineal area and then cleaned the indwelling catheter. Resident said he I have been lying on the tubingthe tubing and it hurt. When the tubing is under myunder my foot it hurtsit hurts and paining, till they change itchange it. CNA C used the same the same gloves throughout the procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11: 09 AM CNA C left the room took off dirty gloves without washing hands or using hand sanitizer went open the door to get moreget more gloves, without washing hands or using hand sanitizer, she then put on a cleaned gloves. Interview with CNA on 9/22/21 at 11:36 AM said had been working with facility for 2 months, on 6:00 AM to 2:00 PM, she had 2 days training and worked with the lead aide for for 2 days and was left to work on the floor on her own and CNA said she forgot to wash her hands or used hand sanitizer. she did know that indwelling catheter bag with 300cc urine shouldurine should not be on the bed. Interview on 09/24/21 at 4:15 PM with DON, she said she had not done any in-services for the staff, CNAstaff, CNA C just started working in the facility. DON said she was going to start doingstart indoing in-services now. On 9/27/21 at DON presented in-services on incontinent/hand washing/indwelling catheter for C.NA C. Record review of facility's policy on Hand Washing Requirements revised 01/2015, revealed in part that staff was required to wash hands before having direct contact with residents and after removing gloves. Record review of [NAME] and [NAME] Clinical Nursing Skills and Techniques 6th edition, Chapter 8 page 192 reflected, .If hands are not visibly soiled, an alcohol-based hand rub should be used for routinely decontaminating hands in the following situation: 1. Before having direct contact with clients .3. After contact with intact skin .4. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressing .5. When moving from a contaminated body site to a clean body site during care .