STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on interview, and record review, the facility failed to ensure the interdisciplinary team had determined that self-administration of medications by a resident was clinically appropriate for 1 of 1 resident (Resident # 5) reviewed for self-administration of medications. The facility failed to ensure that Resident #5 did not self-administer Sodium Bicarbonate (baking soda) without the proper assessment. This deficient practice could place residents who self-administer at risk of adverse events and medication errors. Findings Include Record review of Resident #5's face sheet dated 04/28/22 revealed, a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: history of falling, end stage renal disease, muscle weakness, type 2 diabetes with hyperglycemia, chest pain, vitamin deficiency, constipation, depression and GERD . Record review of Resident #5's Care Plan printed 04/28/22 at 10:25 AM with an effective date of 03/23/21 revealed, Problem- Verbal aggression, resistance of care, refuses to go to dialysis, Goals- Resident will accept redirection from staff for the next 90 days, Intervention- monitor for changes in mental status, be firm and redirect when approaching adult behavior, document behavior in the clinical record. Problem- Resident has exhibited wandering behavior, Goal- current level of mobility will be maintained within a secure environment over the next 90 days, Interventions- assess potential physical causes for wandering, check location/whereabout of resident every 30 minutes on each shift, redirect behavior/activity when wandering is observed. Resident #5's care plan did not include self-administration of medications. Record review of Resident #5's Annual MDS dated [DATE] revealed, impaired vision, moderately impaired cognition as indicated by a BIMS score of 10 out of 15, supervision for all activities of daily living., used a walker and was always continent of both bladder and bowel . Record review of Resident #5's Clinical Progress Notes dated 04/27/22 revealed, The patient was given his scheduled TUMS to take, patient said that his is going to drink some baking soda (Sodium Bicarbonate) that helps whenever he has chest pain. The patient took the baking soda by himself and told me it helped him burp and he felt better. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's NP Progress Note dated 04/28/22 at 02:29 PM, NP #2 wrote- notified by nursing that patient ingested baking soda for indigestion, patient stating tums in ineffective tums discontinued, new order for Pepcid. Record review of Resident #5's Assessment records from admissions (02/11/21) to 06/13/22 revealed, no Assessment for Self-Administration of Medications was completed. Record review of Resident #5's Physician's Orders from admissions (02/11/21) to 06/13/22 revealed, no orders for self-administration of medications. Record review of the facility Accident/Incident Report for 04/2022 revealed no record of Resident #5's self-administration of sodium bicarbonate. In an interview on 04/28/22 at 10:23 AM, the Administrator said that Resident #5 had orders for TUMS but the family brought in the baking soda and the resident stored it in his room. He said while he was unaware Resident #5 had baking soda in his room, after the incident, the Administrator confirmed baking soda was the same as sodium bicarbonate, an over-the-counter medication. The Administrator said he was unaware of how much baking soda the resident consumed. In an interview on 04/28/22 at 12:20 PM, the Administrator said that following the incident, the box of baking soda was removed from Resident #'5's room, the family was notified, and the provider discontinued the order for TUMS, since it didn't work for the Resident . The Administrator said that before a resident can administer their own medications, they must first be assessed for self-administration of medication by the interdisciplinary team and Resident #5 was never assessed for self-administration of medication. He said he did not know the risk of consuming too much sodium bicarbonate (baking soda). An attempt was made to interview Resident #5 on 04/28/22 at 2:00 PM, the resident was irritable and refused to complete an interview. In an interview on 04/28/22 at 02:10 PM, LVN G said, on 04/27/22, a CNA informed her that Resident #5 was having chest pain, so she ran in to check on him. She checked his lungs and vitals and determined that he was found to be in no immediate distress. She said that the resident informed her that the food he ate gave him indigestion, so she offered him TUMS but the resident refused, Resident #5 said he wasn't going to take that shit. LVN G said that Resident #5 said he was going to take baking soda and told her to get out his room. She said she did not see the baking soda and left his room. LVN G said when she returned to the resident's room, he informed her that he took the baking soda and felt better. She said Resident #5 would not show her the baking soda and drove her out of his room and she was unaware of the amount of baking soda he took, so she documented the incident in the resident's progress notes. LVN G said facility policy required that all medication administration be completed under the supervision of nursing staff and residents were not supposed to self-administer medication without previous assessment. She said when Resident #5 informed her he would be taking baking soda for his heart burn, she did not realize it was considered a medication since consumption of baking soda was a known recipe for heart burn so she did not consider it a reportable incident. She said that failure to supervise resident medication administration could result in adverse events and death as a result of suicide. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/02/22 on 2:35 PM, the Administrator said he was the facility's abuse coordinator and all allegations of abuse/neglect, resident altercations, physical/mental abuse as well as infectious diseases should be reported to the state survey agency. He said he did not think the incident of Resident #5 self-administration of medication was a reportable event, but the resident's physician and family were informed of the incident. He stated no head to toe assessment was completed following the incident. The Administrator said no further investigation was done, beyond the removal of the baking soda and notification of the responsible party and provider. He said the risk of self-administration of medication was medication errors or adverse reactions. Record review of the facility policy titled Self-Administration of Medications revealed, Policy- a patient may self-administer medications if the patient it determined safe for the patient and other patients of the facility by the facility's interdisciplinary team. Procedure- an assessment for self-administration of medications must be completed on each patient requesting to self-administer medications and quarterly thereafter. An assessment for self-administration of medication is kept with the patient's medical record under the assessment tab. If it has been determined the patient is capable of self-administering his/her medications, a physicians order must be obtained, a care plan formulated and staff in-serviced. The nursing staff must interview the patient on every shift to verify that all self-administered doses were accomplished All medications for self-administration must be stored in a locked storage area in the patient's room. Record review of the facility policy titled Accidents/Incidents revised May 2016 revealed, 1- An Accident/Incident Report must be completed immediately upon facility staff becoming aware of the occurrence of an accident/incident (to include medication errors) involving a patient . 2- A Witness Statement must be completed at the time of the accident/incident. 3- A head to toe assessment must be performed at the time of the accident/incident and documented every shift for 72 hours. 4- A Psychological Well-Being Care Area Assessment must be completed on all patients with the potential for psychosocial changes resulting from an accident or incident of serious nature or allegation of abuse or neglect to determine any negative psychosocial outcomes . 8- An accident/incident log must be maintained each month in which all accidents/incidents are logged . 17- Accidents/incidents must be reported both internally and externally in accordance with the Reportable Incident Protocol

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 43049 Based on interview and record review, the facility failed to not employ or otherwise engage an individual who had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law for 1 of 5 employees (CNA H) reviewed for criminal history checks, in that: - The facility failed to take proper action during initial employment of CNA H after an employability check revealed that the staff member had her CNA certification in the state of California revoked and she was deemed unemployable since 1999 This failure could place residents at risk of abuse, neglect, misappropriation of property, and/or mistreatment. Findings Include: Record review of CNA H's California Department of Public Health License and Verification Detail Page signed on 06/15/21, retrieved from the staff employee file, provided by the facility on 04/27/22 revealed, CNA H was a Certified Nursing Assistant and her certification was effective on 01/09/1998. The detail page stated that CNA H's certification was revoked on 05-01-1999 and she was deemed not employable. Record review of CNA H's Misconduct Registry/OIG/License and Certification Verification sheet retrieved from her employee file on 04/27/21 revealed, CNA H was hired on 06/15/21. Employee on NAR-EMR from other States Worked: NO, Employable: Yes. There was no reference made to her revoked certificate and her non-employability status by the California Department of Public Health. Record review of the facility provided Background check for CNA H dated 06/13/22 revealed, the search period was 04/13/2015 - 04/13/2022. In an interview on 04/27/22 at 09:40 AM, the HR Coordinator said that she was responsible for running all background checks and credentials for new hires. She said CNA H was hired on 06/15/21 and she was in charge of her screening. The HR Coordinator said that some examples of disqualifying convictions were abuse/assault but corporate determined employability, and it was not her is responsibility to determine if a staff member was eligible for hire or not. She said she filled out the Misconduct Registry/OIG/License and Certification Verification sheet for CNA H but she never noticed the California Department of Public Health License and Verification Detail Page that stated that the staff member had her Certified Nursing Assistant certificate was revoked on 05-01-99 and she was deemed NOT-EMPLOYABLE. In an interview on 04/27/22 at 10:00 AM, the Corporate HR Personnel said that the facility received an anonymous complaint on 03/17/22 that stated CNA H had a criminal history of Credit Card/Debit Card fraud but was still hired by the facility. She said the letter contained CNA H's background check so the information was forwarded to the corporate general counsel. The Corporate HR Personnel said the general counsel investigated the incident and informed her that CNA H was eligible for hire. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/27/22 at 12:14 PM, the Corporate General Counsel said that the primary background check is the DPS system and even though CNA H had a charge of Credit Card/Debit Card Fraud Elder Abuse, she plead to a lesser charge of just Credit Card/Debit Card Fraud which was the basis of eligibility for hire. He said he was unaware that CNA H had a revoked CNA certificate, and she was deemed not-employable in the state of California. In an interview on 04/27/22 on 01:22 PM, CNA H said she had no criminal history that deemed her unemployable and her charge of credit card/debit card fraud was as a result of an allegation made against her by an elderly and confused aunt who accused her of using her credit card without authorization. She stated that she plead guilty to a lesser charge of credit care/debit card fraud, but her original charge involved elderly abuse. CNA H denied that she had her certification in the state of California revoked or that she was deemed unemployable since 05-01-1999. In an interview on 05/12/22 on 01:51 PM, the CDPH Program Technician said according to the state database CNA H CNA certification was revoked and she was deemed unemployable since 1999 due to criminal conviction. In an interview on 06/02/22 on 02:35 PM, the Administrator said as far as he knew the facility did not contact the CDPH to determine why the CNA H's CNA certification was revoked and she was deemed unemployable. In an interview on 06/16/22 at 01:32 PM, the Administrator said failure to properly screen employees could place residents at risk of abuse, misappropriation, and exploitation. Record review of the facility policy titled Abuse Protocol revised 04/2019 revealed,1- the patient has the right to be free from abuse, neglect, mistreatment of resident property and exploitation . 3- Our facility will screen potential employees for a history of abuse, neglect or mistreatment of patient as defined by the applicable legal requirements. This will include attempting to obtain information from previous and/or current employers and checking with the appropriate licensing boards and registries.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, , were reported immediately, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result serious bodily injury, to the administrator of the facility and to other officials (which included the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term facilities) in accordance with State law through established procedures for 2 of 26 residents (Resident #5 and Resident #6) reviewed for abuse. The facility failed to report an Incident of physical abuse between Resident #5 and Resident #6 that occurred on 03/27/22 within 24 hours of notification. This failure could place residents at risk of further abuse and neglect. Findings include: Resident #5 Record review of Resident #5's face sheet dated 04/28/22 revealed, a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: history of falling, end stage renal disease, muscle weakness, type 2 diabetes with hyperglycemia, chest pain, vitamin deficiency, constipation, depression and GERD. Record review of Resident #5's Care Plan, printed 04/28/22 at 10:25 AM revealed, Problem- Verbal aggression, resistance of care, refuses to go to dialysis, Goals- Resident will accept redirection from staff for the next 90 days, Intervention- monitor for changes in mental status, be firm and redirect when approaching adult behavior, document behavior in the clinical record. Problem- Resident has exhibited wandering behavior, Goal- current level of mobility will be maintained within a secure environment over the next 90 days, Interventions- assess potential physical causes for wandering, check location/whereabout of resident every 30 minutes on each shift, redirect behavior/activity when wandering is observed. Resident #5's care plan did not include physical aggression. Record review of Resident #5's Annual MDS dated [DATE] revealed, impaired vision, moderately impaired cognition as indicated by a BIMS score of 10 out of 15, supervision for all activities of daily living, used a walker and always continent of both bladder and bowel. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 04/27/22 at 10:02 AM revealed Resident #5 in his room sitting on the edge of his bed. The resident appeared well fed, well-groomed and in no immediate distress. Resident #5 said when he was done with his meals, he normally pushed his tray out to the front of his doorway for the staff to take. He said when he placed his tray outside on 03/27/22, Resident #6 came by and removed a cinnamon roll from his tray. So he followed him out of the room and hit him in the face. Resident #5 said he had no intention of eating the cinnamon roll, but that did not mean Resident #6 had the right to eat the food. He said that if a similar accident were to happen in the future, he would do it again; he would slap the shit out of him(Resident #6). He said, after the incident, the nurses separated him and took him back to his area. Resident #5 said he was not under additional observation immediately after the incident, and no psych services were rendered. Resident #5 said he did not feel threatened by Resident #6. Record review of Resident #5's Clinical Notes dated 03/27/22 revealed, no documentation of the allegation of abuse between Resident #5 and Resident #6. Resident #6 Record review of Resident #6's face sheet printed 04/28/22 at 12:23 PM revealed, a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included, dementia without behavioral disturbance, difficulty walking and senile dementia. Record review of Resident #6's Quarterly MDS dated [DATE] revealed, impaired vision with use of corrective lenses, short-term memory problem, long-term memory problem, no memory/recall ability, severely impaired cognitive skills for daily decision making, continuously present inattention and disorganized thinking with no fluctuations, delusions and total dependence with all activities of daily living. Record review of Resident #6's Care Plan, printed 04/28/22 revealed, problems- diagnosis of dementia, intervention- reorient to time location, events and activities. Problem- extra time needed to communicate and comprehend during communication related to dementia, intervention- use terms, gestures that resident can understand, repeat as needed, approach in a calm manner, call by name, face during communication. Problem- risk of wandering, goal- will be able to wander in a safe environment without the occurrence of injury and dignity will be maintained. Problem- impulsive behaviors such as pulling the fire alarm, intervention- monitor resident's activities, diversional activities to decrease impulsive behavior. Problem- periods of disorganized thinking, disorganized speech, as evidenced by garbled speech, unable to express thoughts into words, inappropriate answers to simple questions, interventions- move resident to quiet area for 1-on-1 interactions to reduce stimulation An observation on 04/27/22 at 10:50 AM revealed, Resident #6 sitting in a wheelchair in the lounge area across from the nursing station. The resident was not interviewable. He was non-responsive to the surveyor and wandered back and forth between the nursing station and the halls of the resident rooms. In an interview on 04/27/22 at 01:52 PM, CNA E said on 03/27/22, she heard yelling and saw Resident #5 swing at Resident #6. She said after the incident, no instructions were given by administration or nursing management to perform additional observations on Resident #5, and staff just performed their usual resident monitoring. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/28/22 at 09:49 AM, LVN E said she was working the hall when other nurses and aides informed her that Resident #5 hit Resident #6 for eating his food. She said following the event Resident #5 did not leave for further psychological evaluations and was not under any additional monitoring. In an interview on 04/28/22 at 12:20 PM , the DON said she had knowledge of the allegation of physical abuse of Resident #6 by Resident #5 on 03/27/22, but the incident was not reported to the state survey agency by the Administrator until 03/29/22. She said that she could not answer if a resident-to-resident altercation was considered abuse and the facility had a system for notification of such incidents. The DON said that normally her first step would be to notify the Administrator or someone from corporate, in his absence, and they would tell her whether an incident was reportable to the state agency. She said all abuse cases should be reported within 2 hours. So she contacted the corporate department on 03/27/22 about the incident since the Administrator was absent. In an interview on 06/02/22, the Administrator said he was the facility's abuse coordinator and all allegations of abuse/neglect, resident altercations, physical/mental abuse as well as infectious diseases should be reported to the state survey agency. He said allegations of abuse must be reported to the state survey agency within 2 hours for serious injuries or 24 hours if no serious injury occurred. He said, per the facility policy, the incident of abuse between Resident #5 and #6 should have been reported within 24 hours of occurrence. The Administrator said, in his absence, the DON must report allegations of abuse and neglect to the state survey and he did not know why it was not reported on 03/27/22 when it was discovered. So he reported it on 03/29/22 once he became aware of it. In an interview on 06/16/22 at 01:32 PM, the Administrator said failure to timely report incidents could place residents at risk of harm, adverse reactions and places the facility at risk of non-compliance. Record review of the facility policy titled Abuse Protocol revised 04/2019 revealed, 1- the patient has the right to be free from abuse, neglect, mistreatment of resident property and exploitation10. A-The abuse coordinator will a- immediately (within 2 hours) report to DADS and other appropriate authorities incidents of patient abuse as require under applicable regulations and regulatory guidance. D- complete an appropriate assessment of all Patient's involved, e- take all steps necessary to protect the facility's patients from mistreatment while the investigation is in progress . g- be responsible for carrying out any interventions or follow-up steps subsequent to the investigation of any abuse or alleged abuse, neglect, exploitation, or mistreatment. 15- If a patient begins to exhibit inappropriate behavior, the facility will assess the patient and take appropriate steps both to minimize further inappropriate behavior and to protect other patient's even if no allegation of abuse is made. These steps include, as appropriate, providing additional supervision of aggressive patient's, obtaining appropriate medical/psychiatric evaluation and treatment, adjusting facility practices to minimize the risk of further inappropriate behavior . In such instances, the facility will adjust the care plans of the affected patient's accordingly.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview and record review the facility failed to have evidence that all alleged violations are thoroughly investigated and take measure to prevent further potential abuse, neglect, exploitation or mistreatment while the investigation is in process, report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate, corrective action must be taken for 3 of 26 residents (Resident #5, Resident #6 and CR #3) reviewed for abuse and neglect - The facility failed to submit a provider report within 5 working days of the incident to the state survey agency and investigate and allegation of abuse of CR #3 - The facility failed to take action to protect Resident #5 after an incident with Resident #6 These failures could place residents at risk of further abuse and neglect. Findings include: CR #3 Record review of CR #3's face sheet, printed 06/2/22 revealed, a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: hemiplegia , hypertension, unspecified dementia with behavioral disturbances. The resident discharged from the facility on 02/18/22. Record review of CR #3's Care Plan, printed 06/02/22 revealed, no problems pertinent to the identified area of deficient practice Record review of CR #3's Admission MDS dated [DATE] revealed, modified independence to make decisions regarding task of daily life, the resident showed no potential indicators of psychosis such as delusions and hallucinations, and required limited assistance with most ADLs . Record review of the Incident Intake Investigation Worksheet dated 05/26/22 revealed, on 02/18/22 the facility reported an allegation of abuse made by CR #3 at 3:00 PM. The resident said, 2 weeks prior, someone moved her call light and popped her on her hand. The resident could not identify the alleged perpetrator and an LVN performed a head-to-toe assessment at 3:30 PM and no injuries were noted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/16/22 the Administrator said he was not employed at the facility when the incident involving CR #3 occurred. He said following an incident, the facility was required to submit a provider investigation report and report it to the state survey agency within 5 days. The Administrator said he could not locate any documentation to support that CR 3's allegation of abuse was ever investigated or a provider report was ever completed. He said the risk of not identify, investigating and reporting allegations of abuse and reportable incidents places residents at risk of harm/abuse, adverse reactions, inadequate care, and failure to identify root causes. The Administrator said that failure to complete the 5 day provider investigation report made the facility noncompliant with regulations. Record review of CR #3's enter EHR for the entirety of her residency revealed, no documentation of the residents allegation of abuse, no record of assessments completed. Record review of the facility's Accident/Incident Report for 02/2022 revealed, no reported allegations of abuse. Resident #5 Record review of Resident #5's face sheet, dated 04/28/22 revealed, a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: history of falling, end stage renal disease, muscle weakness, type 2 diabetes with hyperglycemia, chest pain, vitamin deficiency, constipation, depression and GERD. Record review of Resident #5's Care Plan printed 04/28/22 at 10:25 AM revealed, Problem- Verbal aggression, resistance of care, refuses to go to dialysis, Goals- Resident will accept redirection from staff for the next 90 days, Intervention- monitor for changes in mental status, be firm and redirect when approaching adult behavior, document behavior in the clinical record. Problem- Resident has exhibited wandering behavior, Goal- current level of mobility will be maintained within a secure environment over the next 90 days, Interventions- assess potential physical causes for wandering, check location/whereabout of resident every 30 minutes on each shift, redirect behavior/activity when wandering is observed. Resident #5's care plan did not include physical aggression or self-administration of medications. Record review of Resident #5's Annual MDS dated [DATE] revealed, impaired vision, moderately impaired cognition as indicated by a BIMS score of 10 out of 15, supervision for all activities of daily living, used a walker and always continent of both bladder and bowel. An observation and interview on 04/27/22 at 10:02 AM revealed Resident #5 in his room sitting on the edge of his bed, the resident appeared well fed, well-groomed and in no immediate distress. Resident #5 said, when he is done with his meals he normally pushes his tray out to the front of his doorway for the staff to take out. He said when he placed his tray outside on 03/27/22 Resident #6 came by and removed a cinnamon roll from his tray so he followed him out of the room and hit him in the face. Resident #5 said he had no intention of eating the cinnamon roll but that didn't mean Resident #6 had the right to eat the food. He said that if a similar accident were to happen in the future he would do it again, he would slap the shit out of him(Resident #6). He said after the incident the nurses separated him and took him back to his area, Resident #5 said he was not under additional observation after the incident and didn't have any additional psych services rendered. Resident #5 said he did not feel threatened by Resident #6. (continued on next page)

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	676357	A. Building B. Wing	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Accident/Incident Report dated 03/27/22 revealed, Patient was in room and became upset because another patient came to his doorway and grabbed a piece of food from his lunch tray. Resident #5 became aggressive and hit the patient on the left side of his face with a closed fist. Record review of Resident #5's Progress notes dated 03/27/22 revealed, no record of the allegation of abuse between Resident #5 and Resident #6. Record review of Resident #5's EHR revealed head to assessments for every shift for 72 hours, neurological assessments, pain assessments or psychosocial assessments were not completed following the allegation of abuse. There were no social services notes in the chart following the allegation of abuse. Record review of Resident #5's Behavioral Clinical Treatment Plan Review (Plan of Care) dated 04/08/22 revealed, Patient discussed incident with another resident where he pushed resident for taking food off his tray. Staff was currently investigating and patient was being put on meds temporarily. Record review of Resident #5's Treatment/Order Update/Change in Condition dated 04/27/22 revealed, refer to psychology for cognitive testing signed by LVN F. Record review of Resident #5's NP's Progress Note dated on 04/28/22 at 02:39 PM, NP #2 wrote, notified by nursing, the patient was involved in an altercation with another resident, patient not injured in altercation but was the aggressor, nursing instructed to update psych. Record review of Resident #5's Frequent Monitoring Record dated 04/29/22 at 13:43 revealed, one- on -one monitoring was initiated on 04/29/22. There were no others for additional behavior monitoring following the incident on 03/27/22 to 04/29/22. Resident #6 Record review of Resident #6's face sheet printed 04/28/22 at 12:23 PM revealed, a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included, dementia without behavioral disturbance, difficulty walking and senile dementia. Record review of Resident #6's Quarterly MDS dated [DATE] revealed, impaired vision with use of corrective lenses, short term memory problem, long term memory problem, no memory/recall ability, severely impaired cognitive skills for daily decision making, continuously present inattention and disorganized thinking with no fluctuations, delusions and total dependence with all activities of daily living. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's Care Plan printed 04/28/22 revealed, problems- diagnosis of dementia, intervention- reorient to time location, events and activities. Problem- extra time needed to communicate and comprehend during communication related to dementia, intervention- use terms, gestures that resident can understand, repeat as needed, approach in a calm manner, call by name, face during communication. Problem- risk of wandering, goal- will be able to wander in a safe environment without the occurrence of injury and dignity will be maintained. Problem- impulsive behaviors such as pulling the fire alarm, intervention- monitor resident's activities, diversional activities to decrease impulsive behavior. Problem- periods of disorganized thinking, disorganized speech, as evidenced by garbled speech, unable to express thoughts into words, inappropriate answers to simple questions, interventions- move resident to quiet area for 1-on-1 interactions to reduce stimulation Record review of Resident #6's Progress Notes dated 03/27/22 revealed, according to witnesses, resident went to Resident #5's room and started eating the other resident's food. Resident #6 the returned to the dining area and Resident #5 came out of his room and went to the dining area looking for Resident #6. Resident #5 punched Resident #6 in the face and told him to stay out of his room. Staff separated the residents, no injuries noted, no distress noted, family and MD notified. Record review of Resident #6's EHR revealed no head to assessments for every shift for 72 hours, neurological assessments, pain assessments or psychosocial assessments were not completed following the allegation of abuse by Resident #6. There were no social services notes in the chart following the allegation of abuse. An observation on 04/27/22 at 10:50 AM revealed, Resident #6 sitting in a wheelchair in the lounge area across from the nursing station. The resident was not interviewable, he was non-responsive to the surveyor and wandered back and forth between the nursing station and the halls of the resident rooms. In an interview on 04/27/22 at 01:52 PM, CNA E said on 03/27/22 she heard yelling and saw Resident #5 swing at Resident #6. She said after the incident no instructions were given by administration or nursing management to perform additional observations on Resident #5 and staff just performed their usual resident monitoring. In an interview on 04/28/22 at 09:49 AM, LVN E said she was working the hall when other nurses and aides informed her that Resident #5 hit Resident #6 for eating his food. She said following the event Resident #5 did not leave for further psychological evaluations. LVN E said following the event Resident #5 was not under any additional monitoring. In an interview on 04/28/22 at 10:14 AM, the DON said that there was no new order for psychiatric evaluation of Resident #5 following his abuse of Resident #6 because the resident was already receiving psych services and his medication regimen had recently been adjusted. She could not say if the changes to Resident #5's medication regimen were due to the incident of abuse. The DON said that once she was alerted of the incident the residents' families were notified and there have been no issues or incidents of physical aggression with Resident #6 since 03/27/22. She said she was unaware that Resident #5 had the intent to repeat his actions if similar events occurred in the future. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/28/22 at 10:23 AM , The Administrator said following an incident of resident-to-resident abuse, staff were expected to separate the residents in case of any future events, notify the family as well as the physician to await new orders for psych services, complete resident assessments for the next 72 hours and make sure to document the details of the event in the resident's progress notes. He said, following the incident, neither Resident #5 or Resident #6 underwent additional observations or assessments and he did not know why the incident was not recorded in the Resident #5's progress notes. The Administrator said even though it was the facility's policy there were no new orders entered for psychological assessments, monitoring, or assessments following the allegation of abuse. He said the resident was just escorted back to his room. In an interview on 04/28/22 at 01:53 PM , the Clinical Social Worker said the first time she was made aware of Resident #5 pushing Resident #6 for taking food of his tray was on her regularly scheduled psychological services appointment on 04/08/22. She said under normal circumstances, the facility or Nurse Practitioner handled any incidents of resident verbal aggression. She said on 04/08/22 she told Resident #5 that he could not treat others like that and about reactive behaviors. She said the expectation was for the patients Nurse Practitioner/MD to be alerted immediately after any incidents of physical aggression. In an interview on 04/28/22 at 12:20 PM, the DON said following an allegation/incident of abuse nursing staff must complete a head-to-toe assessment, psychosocial wellbeing assessments, neurological assessment if a suspected head injury occurred. She said that following the allegation of abuse neither Resident #5 nor Resident #6 received assessments every shift for 72 hours as required per the facility policy. She said the punch to head Resident #6 suffered would be considered a head injury, but no neurological checks were ordered on Resident #6. She said that following the incident no additional supervision was provided to Resident #5 or Resident #6 and psychological evaluation was not completed on Resident #5 until 04/08/22. The DON said that the incident was discussed in the staff morning stand up meeting but Resident #5 and Resident #6's care plans were not updated to reflect the incident. In an interview on 04/28/22 at 02:10 PM, NP# 1 said 04/27/22 the first time she was informed that Resident #5 had a previous incident of reportable physical aggression. She said at the request of the facility, she came in to see the resident and he was irritable because she was asking him the same question everyone had previously asked. NP #1 said when she asked Resident #5 if there was a better way to handle the incident with Resident #6, he said that he would do it again. She said I think he doesn't know any other way to deal with it that it was how Resident #5 had been all his life fight, fight, fight and it was not a form of psychosis that it was just his personality. Nurse Practitioner #1 said when reviewing the resident's chart, she did not see any notes about the incident in which Resident #5 punched Resident #6 and per the records no notification was given to the other doctors or nurse practitioners about the incident. She said when she saw Resident #5 previously, on 04/13/22, she was unaware of the incident of physical aggression, because the event was not in the Resident #5's chart. NP #1 said that following the event, the residents should have been separated immediately and they should remain separated to maintain patient safety. She said Resident #5 was not willing to change rooms because it was the only room with a patio. The Nurse practitioner said based on her assessment today (04/28/22) the resident would do it again. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/02/22, the Administrator said he was the facility's abuse coordinator and immediately following an incident of abuse, nursing staff must first complete a head to toe assessment, pain assessment, assess the resident's range of motion, notify the family and providers of the incident and then complete resident abuse interviews. He said all incidents of abuse must be documented in the resident's chart and there was no documentation to show that both residents were assessed/monitored for 72 hours following the incident as required by facility policy. He said review of the resident's records did not show a psych consultation was requested immediately following the incident on 03/27/22. The Administrator said, under normal circumstances, the psych services provider should have been immediately notified. He said Resident #5 did not get additional observation until 04/29/22, after the state surveyor started investigating the allegation of abuse, and he was now undergoing every 30 minute monitoring. In an interview on 06/16/22 at 1:32 PM, the Administrator said that failure to report allegations of abuse or accidents and incidents to the state survey agency could create lack of proper oversight and noncompliance with regulations. He said the risk of not identifying, investigating and reporting allegations of abuse and reportable incidents, places residents at risk of harm/abuse, adverse reactions, inadequate care, and failure to identify root causes. Record review of the facility policy tiled Follow-up for Potential Head Injury revised 03/2019 revealed, PROCEDURE- following any head trauma, monitor the following; observe for laceration, observe for swelling, observe and inquire if patient has headache or pain, observe for personality changes, observe for alterations in consciousness . DOCUMENTATION- Date, time condition change was identified, observation of the patient at frequent intervals until condition is stable, emergency care provided, notification of physician/family/responsible party and signature and titled. Record review of the facility policy titled Accidents/Incidents revised May 2016 revealed, 1- An Accident/Incident Report must be completed immediately upon facility staff becoming aware of the occurrence of an accident/incident (to include medication errors) involving a patient . 2- A Witness Statement must be completed at the time of the accident/incident. 3- A head to toe assessment must be performed at the time of the accident/incident and documented every shift for 72 hours. 4- A Psychological Well-Being Care Area Assessment must be completed on all patients with the potential for psychosocial changes resulting from an accident or incident of serious nature or allegation of abuse or neglect to determine any negative psychosocial outcomes . 8- An accident/incident log must be maintained each month in which all accidents/incidents are logged . 17- Accidents/incidents must be reported both internally and externally in accordance with the Reportable Incident Protocol (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled Abuse Protocol revised 04/2019 revealed,1- the patient has the right to be free from abuse, neglect, mistreatment of resident property and exploitation . 3- Our facility will screen potential employees for a history of abuse, neglect or mistreatment of patient as defined by the applicable legal requirements. This will include attempting to obtain information from previous and/or current employers and checking with the appropriate licensing boards and registries . 10. A-The abuse coordinator will a-immediately (within 2 hours) report to DADS and other appropriate authorities incidents of patient abuse as require under applicable regulations and regulatory guidance. D- complete an appropriate assessment of all Patient's involved, e- take all steps necessary to protect the facility's patients from mistreatment while the investigation is in progress . g- be responsible for carrying out any interventions or follow-up steps subsequent to the investigation of any abuse or alleged abuse, neglect, exploitation, or mistreatment. 15- If a patient begins to exhibit inappropriate behavior, the facility will assess the patient and take appropriate steps both to minimize further inappropriate behavior and to protect other patient's even if no allegation of abuse is made. These steps include, as appropriate, providing additional supervision of aggressive patient's, obtaining appropriate medical/psychiatric evaluation and treatment, adjusting facility practices to minimize the risk of further inappropriate behavior . In such instances, the facility will adjust the care plans of the affected patient's accordingly. 20- The Abuse Prevention Coordinator will report allege incidents of patient abuse to DADS In addition, the results of all investigations will be reported to the state agency within 5 working days of the incident if the alleged violations are verified are appropriate, corrective action will be taken

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain grooming and personal hygiene for 5 of 6 residents (Resident #2, #4, #9, Anonymous and CR #1) reviewed for ADLs. 1. The facility failed to provide incontinent care for Resident #2 for more than 2 hours. Resident #2's brief was saturated with urine and soaked through her pants and onto the pad of the wheelchair. 2. The facility failed to provide showers to Resident #4, Resident #9, Anonymous, and CR #1, in compliance with the shower schedule. This deficient practice could place residents at risk of a decline in their sense of well-being, level of satisfaction with life, at risk for skin breakdown and infection. Findings include: Resident #2: Record review of Resident #2 face sheet printed on 06/02/2022 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: stroke, hypertension (high blood pressure), epilepsy (seizure), hemiplegia (paralysis of one side of the body), dysphagia (difficulty swallowing), repeated falls and UTI. Record review of the Annual Minimum Data Set (MDS) resident assessment date completed on 10/22/2021 revealed Resident #2 had no speech, rarely made self-understood and usually understood others. She had long-term memory problems and her cognitive skills for daily decision making was moderately impaired. She was totally dependent on one staff for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. She used a wheelchair for mobility. She was always incontinent of urine and bowel. Record review of Resident #2's care plan effective date 06/24/2016 to present revealed in part; -Problems: Resident #2 is at risk for falls related to impaired mobility -Interventions included: respond promptly to calls for assistance to the toilet -Problems: Resident #2 is always incontinent of bowel movement and bladder. -Interventions included: apply moisture barrier to buttocks, check for incontinence, clean and dry skin if wet or soiled, document when incontinent, perform complete skin assessment, use pads/briefs to manage incontinence -Problems: Resident #2 is at risk for skin breakdown, related to impaired mobility and incontinence (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	-Interventions included: check skin for redness, skin tears, pressure areas, report any signs of skin breakdown. Observation and interview on 5/29/2022 at 5:30 PM Resident#2 sitting in a wheelchair, in her room and visiting with family. Resident #2 was alert and non-verbal. The family stated the staff did not check on her often enough. The family had been at the facility since around 3:30 PM and stated no one has come by to check her. The family stated they have seen the staff change Resident #2 and put her right back into the wet chair and that was just not right. The family then assisted Resident #2 to a standing position. Her pants had a large dark wet stain. The family stated the pad on the wheelchair was also wet. The family turned the call light on and requested staff to change Resident #2. Observation and interview on 5/29/2022 at 6:30 PM CNA A removed Resident #2's pants, unfastened the adult brief. There was a strong urine odor, and the brief was saturated with yellow urine. After incontinent care, CNA said the pants were clean and ready to put back on the resident. The Surveyor asked if the pants were wet or not. CNA A looked closer and said they were wet. After Resident #2 was dressed, with clean dry pants, CNA A was just about to transfer Resident #2 back into the wheelchair. The Surveyor asked about the possible wet wheelchair pad. CNA A said she should and would usually wipe down the wheelchair. Then she wiped it down with clean cleansing wipes and transferred the resident into the wheelchair. CNA A stated Resident #2's skin was red and was probably from sitting a long time. Interview on 6/02/2022 at 12:45 PM, LVN D stated residents should be checked for incontinence typically every 2 hours, depending on the resident. It worked out to every hour when the nurses also check every 2 hours. LVN D stated wheelchairs are cleaned on the night shift. She stated she thought she had educated the night staff about cleaning dirty or wet wheelchairs as well as when the resident is visibly soiled and if the pants are soaked. Therapy or central supply inspect the cushions if soiled. LVN D did not state how often cushions were inspected by therapy or central supply. It could cause wounds or skin breakdown if a resident remains seated in wet clothes and cushions. If severe enough, the resident should shower or have a bed bath. Redness to the skin on a resident's buttocks could be from sitting in urine or fecal matter and some people's skin are easily irritated. Resident #4: Record review of Resident #4's face sheet printed on 5/19/2022 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: type 2 diabetes, metabolic encephalopathy (chemicals adversely affecting brain function), kidney stones, COPD, PVD, pulmonary embolism (a blood clot in a major blood vessel in the lungs), excess urine accumulating in the kidney, UTI, hypertension (high blood pressure) and open wound of right buttocks. Record review of the Admission Minimum Data Set (MDS) resident assessment date completed on 05/05/2022 revealed Resident #4 had a BIMS score of 14 indicating her cognition was intact. She required extensive assistance with one person for bed mobility, transfers, dressing, toilet use and personal hygiene. Record review of Resident #4's care plan effective date 04/28/2022 to present, revealed in part; -Problems: Resident #4 requires extensive assistance to total assistance with ADLs and functional mobility. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	-Interventions included: set-up, assist, give shower, shave, oral, hair, nail care on schedule and as needed. -Problems: Resident #4 was totally dependent on the staff. -Interventions included: bathe/shower 3 times a weekly. Record review of facility's shower schedule indicated Resident #4 was scheduled for showers every Tuesdays, Thursdays, and Saturdays at 6:00 AM to 2:00 PM. Record review of Resident #4's ADL Verification Worksheet for dates 4/26/2022 to 5/19/2022 revealed the resident received bathing on 5/06/2022, 5/09/2022 and 5/16/2022. Observation and interview on 5/19/2022 at 11:15 AM, Resident #4 was lying in bed on her back. She was alert, oriented and said she always had back pain, she preferred to have bed baths instead of showers at that time. She had been very itchy in the perineal area and got sores when sitting in feces for hours. She stated she never had itching or redness prior to admission to the facility. She stated she had a bath on Monday 5/16/2022 and thought she was supposed to get them only weekly. She was unaware of the three times per week shower schedule. Interview on 5/19/2022 at 1:00 PM, Resident #4 stated, prior to admitting to the facility, she did not have any redness or itching. The itching started about one week ago. She stated prior to Monday's (5/16/2022) bath she had not been offered a bath for 3 weeks. She preferred to not have waited for 3 weeks before getting a bath. Observation on 5/19/2022 at 11:32 AM, with assistance from CNA C, Resident #4's skin was assessed. Resident #4's entire perineal area: groin folds, labia area, extending to the buttocks was a diffused deep red color. There were multiple scattered red bumps along abdominal folds, left hip, buttocks, and groin area. The left upper, outer hip had a long bright red, shiny raw area where the elastic of the brief contacted the skin. Interview and record review on 06/02/2022 at 3:00 PM, LVN D stated she conducted a head-to-toe skin assessment on 5/19/2022 after the Surveyor visited Resident #4. LVN D stated Resident #4 had a dressing over a wound to the right buttocks and was unable to recall anything else about the skin. LVN D noted on a body form drawing that Resident #4 had discoloration to the left arm, a foley catheter and wound on the right buttocks. LVN D's assessment of Resident #4's skin condition was unlike the Surveyor's assessment. Record review of Resident #4's clinical notes dated 05/19/2022 at 5:33 PM written by LVN D read in part: . performed head to toe skin assessment. Patient has a wound to her right buttocks. In addition, she has some scattered bruises to her upper extremities . Resident #9: Record review of Resident #9's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included UTI, fracture of the femur, hypertension, urine retention, GERD, osteoarthritis (inflammation of joints), and anxiety. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #9's quarterly Minimum Data Set (MDS) resident assessment completed on date 03/22/2022 revealed a BIMS score of 14 indicating she was cognitively intact. She required limited assistance of one staff for bed mobility, transfers, locomotion both on and off the unit; dressing, toilet use and personal hygiene. She used a wheelchair for mobility. Record review of the facility shower schedule indicated Resident #9 was scheduled Mondays, Wednesday, and Fridays from 2:00 PM to 10:00 PM. Record review of Resident #9's ADL Verification Worksheet for Bathing on dates 3/30/2022 to 4/26/2022, printed on 5/19/2022 at 10:27 AM revealed inconsistencies compared to ADL Verification Worksheet for Bathing on same date range of 3/30/2022 to 4/26/2022, printed on 4/27/2022 at 12:10 PM. The worksheet printed on 5/19/2022 indicated that on 04/05/2022 at 5:03 AM the resident was bathed, at 12:59 PM the resident was not bathed, and at 5:14 PM the resident was bathed. The worksheet printed on 4/27/2022 indicated on 04/05/2022 at 5:03 AM, 12:57 PM and 5:12 PM the bathing did not occur. The worksheet printed on 4/27/2022 indicated care was provided for showers or bed baths on all dates except for 4/05/2022, 4/15/22, 4/17/22, 4/18/22 and 4/26/22. This information did not match the information on the worksheet printed on 5/19/2022. Record review of Resident #9's Skin Monitoring: Comprehensive CNA Shower Review sheets revealed showers were given on 2/14/22, 2/21/2022 and 3/14/2022. There were no other shower sheets for Resident #9. In an interview on 4/27/2022 at 10:20 AM, Resident #9 stated her skin had been itchy and she never experienced this before. She said it may be due to staying in wet briefs for a long time and not getting showers. She stated she had to ask for medication for the itching in the middle of the night so she could sleep. At home she would shower every night. On Monday mornings, she would start asking about showers. She told the staff she would like a shower anytime it was available and would be lucky to get one shower a week. In an interview on 4/27/2022 at 11:20 AM, LVN F stated she ensured residents received showers by checking in with the residents and a shower schedule is located at each nurses' station that nursing staff should be following. The residents should get showers three times a week. In an observation and interview on 04/27/2022 at 11:33 AM, Resident #9 was helped to the toilet by LVN H. Resident #9's skin on her buttocks was pink. Resident #9 stated the area that itched the most was her front and skin folds where the pull-ups contact the skin. In an interview on 4/27/2022 at 11:40 AM, LVN H stated she had a list of scheduled showers and this is how she knew who needed them. She stated the frequency of showers/baths depends on the resident condition and she ensured residents received their showers/baths by rounding and talking with the CNAs. LVN H did not state how often per week residents were scheduled for showers/baths. LVN H stated she was aware Resident #9 had orders for itch medication that she had been receiving this. In an interview on 4/28/2022 at 11:57 AM, CNA G stated shower sheets were supposed to be filled out every shower day. The CNA's responsibilities was to sign the sheet, notify the nurse then the nurse will talk with the resident if they refuse. Resident #9 was limited assistance with showers, incontinent care should be on another screen on the computer and not documented under bathing. The questions in the bathing section in Resident #9's chart may not be answered correctly. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Anonymous: In an interview and observation during the investigation, Anonymous stated, the changing of adult briefs was done timely during the day but not at night. At night, the adult brief would be totally soaked. Anonymous was, swimming in it and sometimes they won't come for a very long time to change the brief. They don't do a thorough job cleaning either. Other times all they do is change the wet brief and not wash the skin. Anonymous stated their private areas had been very itchy. Red scratch marks were present on the right thigh. Bilateral inner groin and inner thighs had large areas of diffused (spread over a wide area) reddish-brown skin. The right buttocks had red area at the gluteal cleft. Flakes of white substance was clinging to the skin. Record review of the Bathing ADL Verification Worksheet for Anonymous revealed there were only two days during the month of May 2022 that bathing was provided in a 10-day period. Record review of the physician order dated 5/17/2022 for weekly head to toe skin assessment for Anonymous, revealed no initials documented on the dates ordered and no description of skin condition were documented. In an interview on 06/16/2022 at 2:00 PM, the Regional Director of Clinical Services stated if the physician orders for weekly skin assessment was not initialed, then it may not have been completed. In an interview on 4/28/2022 at 12:20 PM, the DON stated residents were given showers/baths three times per week. The use of shower sheets was new and was intended to catch skin issues. She stated she did not know exactly when the use of shower sheets began. The DON stated she was aware if residents were receiving showers three times a week or not when doing rounds and during report. During rounds and report she expected the nurses to question the CNAs about any skin issues noted during resident care and of any refusals to bathe. She stated the plan was for CNAs to be in-serviced on ADL documentation in the computer becauseaccuracy was a problem. She stated the aides may have clicked through the sections very quickly without reading and there were many new staff in orientation who were not familiar with documentation. CR #1: Record review of CR#1's face sheet printed on 5/19/2022 revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged to the hospital on 4/29/2022. Her diagnoses included acute ischemia (decreased blood flow) of intestine, metabolic encephalopathy (alterations of brain chemistry), type 2 diabetes, atrial fibrillation (heartbeat too slow, too fast or in an irregular way), myocardial infarction (heart attack), pleural effusion (excessive collection of fluid in space around the lungs), dementia, anemia, acute ischemia of large intestine (blockage causing a decrease in blood flow to the intestine), perforation of intestine (a hole through the intestine), abdominal pain, sepsis (infection in the bloodstream) and hypertension. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Record review of CR#1 admission Minimum Data Set (MDS) resident assessment completed on date 4/07/2022 revealed CR#1 had a BIMS score of 6 indicating she had severe cognitive impairment. She had clear speech, had the ability to make self-understood and had the ability to understand others. CR#1 required extensive assistance of two staff for her bed mobility and toilet use. The resident required extensive assistance of one staff for transfers and dressing. The resident required limited assistance from one staff for walking and personal hygiene. The resident used a walker or wheelchair. The resident was always incontinent of bowel and always incontinent of urine. The resident was at risk of developing pressure ulcers or skin injuries. The resident had a surgical wound and required wound care. Record review of CR#1's care plan effective 3/24/22 revealed in part: -Problems: CR#1 was diabetic and at risk for frequent infections. -Interventions included: Monitor skin for changes, redness, circulatory problems, breakdown and report to MD and RP -Problems: CR #1required the use of an Ostomy as evidenced by a Colostomy. -Interventions included: provide ostomy care; monitor site for swelling, pain, redness. -Problems: CR#1 had current skin concerns: excoriation (stripped of skin) to sacral area, effective date 4/26/2022. -Interventions included: incontinent care; turn and reposition; perform treatments per order, if no improvement in 2 weeks then report to MD; monitor areas for increased breakdown, s/s of infection and report to MD .keep MD and RP. -Problems: CR#1 required extensive assistance for toileting, effective date 4/7/2022. -Interventions included: provide hygiene after voiding/bowel movements to prevent skin breakdown. Apply moisture barriers; select clothing easily removed and change incontinence pad/brief. -Problems: CR#1 is always incontinent of bowel movement (no episodes of continent bowel movements) -Interventions included: Apply moisture barrier to buttocks; check for incontinence-clean and dry skin if wet or soiled; document when CR#1 is incontinent; perform complete assessment of skin and note areas of redness; use pads/briefs to manage incontinence. -Problems: Urinary continence - CR#1 is always incontinent. -Interventions included: Apply moisture barrier to buttocks; check for incontinence-clean and dry skin if wet or soiled; document when CR#1 is incontinent; perform complete assessment of skin and note areas of redness; use pads/briefs to manage incontinence; check for incontinence and change if wet/soiled; clean skin with mild soap and water; apply moisture barrier; check skin for areas of redness and report any changes to the nurse. Turn/reposition. Use pads/briefs to manage incontinence. -Problems: CR#1 is at risk of pressure ulcer. - (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Interventions included: Check skin for redness, skin tears, swelling or pressure areas. Report any signs of skin breakdown. Use pillows, pads, or wedges to reduce pressure on heals and pressure points. Turn/reposition. Do not massage skin over pressure areas. -Problems: CR#1 was on antibiotics and at risk for adverse reactions to IV Zosyn x 14 days, effective 3/24/22 - 4/26/2022. -Interventions included: Monitor resident for adverse reactions specific to the medication. Follow universal/standard precaution to prevent cross contamination and spread of infection. -Problems: CR#1's ADL functions: extensive assist with ADLs and functional mobility. -Interventions included: set-up assistance: give shower, shave, oral, hair, nail care on schedule and PRN. Record review of CR #1's ADL verification worksheet for bathing revealed between 3/23/2022 and 4/29/2022, CR#1 was bathed 4 times: 4/12/2022, 4/18/2022, 4/26/2022 and 4/28/2022. In an interview on 5/26/2022 at 1:15 PM the first hospital nurse stated that on 4/30/2022 at approximately 1:53 AM, CR#1's was received on her unit. She conducted a full body assessment. The sacrum had a pressure ulcer, multiple skin tears and bruises. The nurse stated the family was concerned. The second hospital nurse stated she also saw CR#1 in the morning of Saturday 4/30/2022 and gave CR#1 a bath. The pressure ulcer was at least a stage 2. There was large excoriation up her back side, groin, and thigh. The wounds were red, very excoriated over the entire buttocks area, including folds of thigh, groin, and labia. The TV remote was found on CR#1's back under her clothing. The family was looking for the remote the previous Tuesday or Wednesday. The second nurse said she assumed the patient had not been changed at the facility. The patient had a skin tear to the right hip fold crease. This area was red and raw and the scabs were red. The first hospital nurse confirmed that on 4/30/2022 at 10:00 AM or 11:00 AM, she was with CR#1 when the family took pictures of CR#1's skin. The second hospital nurse said CR#1 had a UTI and the urine was orange and fuzzy. An external female catheter with low suction was used to collect urine in a clear canister by the bedside. The first hospital nurse stated CR#1 was not making urine at first. Then IV fluids were started, and the urine output increased. The sacral pressure ulcer was weeping. The first hospital nurse and the hospital quality director stated the skin condition of CR#1 could be caused by lack of turning, not keeping the skin clean, poor hygiene, poor nutritional support, not washing the skin, not using skin barrier cream, wearing adult briefs versus leaving open to air and all of these could possibly lead to moisture associated skin disorder. If the patient had a UTI then it would be possible that the urine could cause a fungal skin infection. The hospital patient safety specialist stated the pressure ulcer had yellow slough and therefore was unstageable. The first and second hospital nurse confirmed the body skin assessment drawing tool used was the correct description of CR#1's condition. They stated the skin tool was signed by two nurses and used when entering data into the electronic health records. The nurse stated lab results indicated pseudomonas in the urine. Interview on 6/16/2022 at 2:00 PM, the Regional Clinical Services Director stated he would have to research regarding the discrepancies on the weekly skin assessment descriptions, that the facility was aware the wounds are not descriptive and had hired a new wound care nurse. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's policy and procedure titled Activities of Daily Living, Cantex Continuing Care Network, March 2013 read in part: 1. Every effort must be made to assure that assignments of nurses and nurse aides to Patients are as consistent as possible. 2. A Daily Care Guide must be prepared from the electronic medical record (EMR) to assist direct care staff in providing assistance to Patients in their activities of daily living. The Daily Care guide for each Patient must be updated at least on admission, readmission and upon any change in condition affecting activities of daily living Record review of the facility's policy and procedure titled Bath-Bed-Shower, Cantex Continuing Care Network, March 2013 read in part: Responsibility-Licensed Nurse and Nursing Assistant. Purpose-To cleanse, refresh, and soothe the patient, to stimulate circulation and to inspect the body . Record review of facility policy and procedure titled Perineal Care Protocol, Cantex Continuing Care Network, February 2022 read in part: .Cleansing the perineal area between showers or baths help prevent irritation, infection and skin breakdown as well as keeping the patient comfortable

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan and the residents' choices for 2 of 10 residents (CR #1 and Resident #8) reviewed for quality of care. 1. The facility failed to properly identify a change in condition for CR#1 who developed erythema to skin secondary to a fungal infection. 2. The facility failed to timely transport Resident #8 to the hospital following a fall that resulted in a right humeral neck (the top of the upper arm bone at the shoulder joint) fracture. This failure could place residents at risk for unidentified changes in condition, delay of treatment, infection, decline in health and hospitalization . Findings Include: CR #1 Record review of CR#1's face sheet printed on 5/19/2022 revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged to the hospital on 4/29/2022. Her diagnoses included acute ischemia (decreased blood flow) of intestine, metabolic encephalopathy (alterations of brain chemistry), type 2 diabetes, atrial fibrillation (heartbeat too slow, too fast or in an irregular way), myocardial infarction (heart attack), pleural effusion (excessive collection of fluid in space around the lungs), dementia, anemia, acute ischemia of large intestine, perforation of intestine, abdominal pain, sepsis (infection in the bloodstream) and hypertension. Record review of CR#1 admission Minimum Data Set (MDS) resident assessment completed on 4/07/2022 revealed CR#1 had a BIMS score of 6 indicating she had severe cognitive impairment. She had clear speech, had the ability to make self-understood and had the ability to understand others. CR#1 required extensive assistance of two staff for her bed mobility and toilet use. The resident required extensive assistance of one staff for transfers and dressing. The resident required limited assistance from one staff for walking and personal hygiene. The resident used a walker or wheelchair. The resident was always incontinent of bowel and always incontinent of urine. The resident was at risk of developing pressure ulcers or skin injuries. The resident had a surgical wound and required wound care. Record review of CR#1's care plan effective 3/24/22 revealed in part: -Problems: CR#1 was diabetic and at risk for frequent infections. -Interventions included: Monitor skin for changes, redness, circulatory problems, breakdown and report to MD and RP -Problems: CR #1required the use of an Ostomy as evidenced by a Colostomy. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Interventions included: provide ostomy care; monitor site for swelling, pain, redness. -Problems: CR#1 had current skin concerns: excoriation (stripped of skin) to sacral area, effective date 4/26/2022. -Interventions included: incontinent care; turn and reposition; perform treatments per order, if no improvement in 2 weeks then report to MD; monitor areas for increased breakdown, s/s of infection and report to MD .keep MD and RP. -Problems: CR#1 required extensive assistance for toileting, effective date 4/7/2022. -Interventions included: provide hygiene after voiding/bowel movements to prevent skin breakdown. Apply moisture barriers; select clothing easily removed and change incontinence pad/brief. -Problems: CR#1 is always incontinent of bowel movement (no episodes of continent bowel movements) -Interventions included: Apply moisture barrier to buttocks; check for incontinence-clean and dry skin if wet or soiled; document when CR#1 is incontinent; perform complete assessment of skin and note areas of redness; use pads/briefs to manage incontinence. -Problems: Urinary continence - CR#1 is always incontinent. -Interventions included: Apply moisture barrier to buttocks; check for incontinence-clean and dry skin if wet or soiled; document when CR#1 is incontinent; perform complete assessment of skin and note areas of redness; use pads/briefs to manage incontinence; check for incontinence and change if wet/soiled; clean skin with mild soap and water; apply moisture barrier; check skin for areas of redness and report any changes to the nurse. Turn/reposition. Use pads/briefs to manage incontinence. -Problems: CR#1 is at risk of pressure ulcer. - Interventions included: Check skin for redness, skin tears, swelling or pressure areas. Report any signs of skin breakdown. Use pillows, pads, or wedges to reduce pressure on heals and pressure points. Turn/reposition. Do not massage skin over pressure areas. -Problems: CR#1 was on antibiotics and at risk for adverse reactions to IV Zosyn x 14 days, effective 3/24/22 - 4/26/2022. -Interventions included: Monitor resident for adverse reactions specific to the medication. Follow universal/standard precaution to prevent cross contamination and spread of infection. -Problems: CR#1's ADL functions: extensive assist with ADLs and functional mobility. -Interventions included: set-up, assist, give shower, shave, oral, hair, nail care schedule and PRN. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of CR#1's April 2022 physician orders revealed, in part; an order to apply moisturizer cream: apply skin barrier to sacrum every day until resolved, start date 3/23/2022. Weekly head-to-toe assessments once a week starting 3/24/2022. Order to discontinue the foley catheter on date 4/6/2022. Wound treatment-zinc oxide 3 times a daily; cleanse sacrum may use wipes and apply barrier cream until redness resolves starting 4/13/2022. Apply zinc oxide to inner thighs for preventative treatment once a day starting 4/16/2022. Wound treatment - collagen once daily: clean sacrum with normal saline, pat dry, apply collagen and cover with dry dressing starting on 4/27/2022. Record review of hospital records revealed on 3/22/2022 at 4:24 AM prior to admission to the facility on [DATE], CR#1 had a stage 2 pressure injury to the sacrum. Record review of CR#1's nursing note dated 3/23/2022 at 3:35 PM written by LVN B revealed in part .an admission skin assessment, .Multiple bruises also on bilateral lower legs, different stages of healing, colostomy site to the left side of abdomen. Drainage tubes to the left upper and mid lower abdomen .PICC line to the inner right arm .Sacrum has peeling and red area . Record review of CR#1's nursing note dated 03/24/2022 at 2:30 PM, LVN A wrote in part .resident has a stage 2 sacral wound . Record review of CR#1's wound assessment dated [DATE] (no time) written by LVN C revealed a non-pressure-moisture associated skin damage(excoriation) located on the sacrum was identified in-house and the date of onset was 4/12/2022. It was 4 x 4 cm in length and width. There was scant amount of exudate (drainage). The exudate was described as serosanguineous (composed of red blood cells and serous fluid). Surrounding skin color was bright red. The wound appearance was redness. The surrounding tissue had maceration (oversaturation of skin due to prolonged exposure to moisture). Treatments: barrier cream. Record review of CR#1's wound assessment dated [DATE] (no time) written by LVN C revealed a non-pressure-moisture associated skin damage (excoriation) located on the sacrum was identified in-house on 4/12/2022. It was 3.5 x 3 cm in length and width. Surrounding skin color was bright red. The wound's appearance was redness. Treatments: barrier cream. Record review of CR#1's wound assessment dated [DATE] (no time) written by LVN C revealed a non-pressure-moisture associated skin damage (excoriation) located on the sacrum was identified in-house on 4/12/2022. It was 3.5 x 4 cm in length and width. There was small amount of exudate. Surrounding skin color was bright red. The wound appearance was redness. The surrounding tissue had maceration. Further investigation of wound care notes revealed there were no assessments related to the multiple bruising to the lower legs mentioned in the 3/22/2022 admission skin assessment nursing notes. Record review of the 2022 weekly head to toe skin assessments revealed on 3/30/2022, 4/06/2022 and 4/13/2022 CR#1's skin condition was noted as non-pressure. On 4/20/22 and 4/27/2022 the skin condition was noted as clear. Record review of CR #1's ADL verification worksheet for bathing between 3/23/2022 and 4/29/2022, revealed evidence that CR#1 was bathed only 4 times: 4/12/2022, 4/18/2022, 4/26/2022 and 4/28/2022. There was no documentation for the 12 other dates the resident was scheduled for bathing. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's undated shower schedule revealed residents were to be showered three times per week. Record review of a nursing clinical note on 4/29/2022 at 4:53 PM, written by LVN D revealed in part .Family requested that the patient be sent out to hospital for evaluation and treatment because she was acting abnormal . Record review of ambulance run sheet revealed on 4/29/2022 at 6:09 PM the ambulance arrived at the facility and transported CR#1's to the hospital on 4/29/2022 at 6:46 PM. The acute symptoms listed were abnormal breathing, hypoxemia (low blood oxygen levels), confusion/disorientation, altered mental status, weakness, malaise, and fatigue/lethargy. Interview on 5/18/2022 at 1:32 PM, LVN C stated CR#1's initially had excoriation on her bottom and she did not have a pressure ulcer. She remembered educating the Admission nurse (LVN A no longer employed at the facility) regarding staging because they (the hospital) staged it as a 2. MASD and excoriation did not get better. She did not have a stage 2 when admitted . She did end up with a stage 2. Her MASD was clearing up pretty well but got worse when she did not see her over the weekend (04/23/2022 and 4/24/2022) and it was a stage 2 the week she discharged . She put in a request to see the wound care doctor that week but she discharged before then. Excoriated area was more reddened. It was not wide-spread on her buttocks, it was just the area immediately around the sacrum. She was informed by way of Stop and Watch that the sacrum got worse and did not know the reporting nurse's name. LVN C stated a cause of MASD could be from declining health or being in wet or soiled brief too long. She was on antibiotics. So loose stools could lead to skin breakdown. As far as she knew she was getting sufficient incontinence care. LVN C did not mention the condition of the skin as described by the hospital nurses and described in the hospital notes when the resident was admitted on [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/26/2022 at 1:15 PM the first hospital nurse stated that on 4/30/2022 at approximately 1:53 AM, CR#1's was received on her unit. She conducted a full body assessment. The sacrum had a pressure ulcer, multiple skin tears and bruises. The nurse stated the family was concerned. The second hospital nurse stated she also saw CR#1 in the morning of Saturday 4/30/2022 and gave CR#1 a bath. The pressure ulcer was at least a stage 2. There was large excoriation up her back side, groin, and thigh. The wounds were red, very excoriated over the entire buttocks area, including folds of thigh, groin, and labia. The TV remote was found on CR#1's back under her clothing. The family was looking for the remote the previous Tuesday or Wednesday. The second nurse said she assumed the patient had not been changed at the facility. The patient had a skin tear to the right hip fold crease. This area was red and raw and the scabs were red. The first hospital nurse confirmed that on 4/30/2022 at 10:00 AM or 11:00 AM, she was with CR#1 when the family took pictures of CR#1's skin. The second hospital nurse said CR#1 had a UTI and the urine was orange and fuzzy. An external female catheter with low suction was used to collect urine in a clear canister by the bedside. The first hospital nurse stated CR#1 was not making urine at first. Then IV fluids were started, and the urine output increased. The sacral pressure ulcer was weeping. The first hospital nurse and the hospital quality director stated the skin condition of CR#1 could be caused by lack of turning, not keeping the skin clean, poor hygiene, poor nutritional support, not washing the skin, not using skin barrier cream, wearing adult briefs versus leaving open to air and all of these could possibly lead to moisture associated skin disorder. If the patient had a UTI then it would be possible that the urine could cause a fungal skin infection. The hospital patient safety specialist stated the pressure ulcer had yellow slough and therefore was unstageable. The first and second hospital nurse confirmed the body skin assessment drawing tool used was the correct description of CR#1's condition. They stated the skin tool was signed by two nurses and used when entering data into the electronic health records. The nurse stated lab results indicated pseudomonas in the urine. Interview on 06/02/2022 at 12:40PM, LVN D said CR#1 had a PICC line to the upper right arm, a Colostomy on the right side of abdomen, two drainage tubes on the left side of abdomen and no signs of infection to the sacral area. She illustrated these areas by drawing on a body form sheet. There was no mention of the unstageable pressure ulcer to the coccyx, the wide-spread excoriation to the buttocks, perineal area, perianal area, multiple skin tears and bruises that were noted in the interview and record review of CR #1's admission to the hospital on 4/30/2022. Interview on 06/16/2022 at 2:00 PM, the Administrator stated the risks of not performing incontinent care for any resident requiring assistance was skin breakdown, poor hygiene, infection and UTI. Interview on 6/16/2022 at 2:00 PM, the Regional Clinical Services Director stated he would have to research regarding the discrepancies on the weekly skin assessment descriptions, that the facility was aware the wounds are not descriptive and had hired a new wound care nurse. In a telephone interview on 06/17/2022 at 4:45 PM the family stated CR#1 passed away at home on 06/02/2022. Record review of hospital records revealed on 4/30/2022 at 2:20 AM, CR#1 had multiple scattered scabs to both lower legs and a skin tear on the right upper-outer left hip CR#1 had an unstageable pressure injury to the coccyx which was present on admission, excoriation to bilateral gluteal fold and the surrounding tissue was also excoriated. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- CR#1 also had excoriation, erythema (redness) and non-blanchable (skin that did not lose redness with pressure) skin to bilateral groin area. Record review of CR#1's body form skin assessment drawing, which was not a part of the patient's medical records dated 4/30/2022 and signed by two hospital nurses reflected the written description of the wounds. Record review of CR#1's wound evaluation written by the hospital wound care nurse dated 5/02/2022 at 10:30 AM revealed in part: . Wound to right and left lower medial buttocks, gluteal cleft, perianal area, perineum and both labia: Erythema secondary to fungal rash .Sacrum: unstageable pressure injury, 3 cm diameter, wound bed is 100% yellow slough, scant serosanguinous drainage, peri wound: erythema. Right and left groin and beneath pannus (dense layer of abdominal fatty tissue): partial thickness fissures and erythema . Recommendations: 1. Apply Nystatin powder twice daily to right and left lower medial buttocks, gluteal cleft, perianal area, perineum, bilateral groin and both labia Record review of CR#1's hospital records revealed microbiology results dated 5/02/22 at 12:18 PM that the urine culture collected on 4/29/22 at 10:57 PM results were Pseudomonas aeruginosa (a multidrug resistant pathogen). Record review of CR#1's hospital records revealed on 4/30/2022 at 2:54 AM, a physician order read in part . Female External Urinary Catheter .set wall suction at low continuous suction, Incontinence Associated Dermatitis . Record review of CR#1's hospital records dated 4/30/2022 at 3:10 AM revealed the History and Physical written by the physician, read in part: .Chief Complaint: .family states patient is more lethargic, weakness and increased AMS .Assessment/Plan: Pelvic abscess-start antibiotic, IR (interventional radiology) consulted for drain, surgery and ID (infectious disease) consulted; Perforated viscus (internal organs); UTI (urinary tract infection)-continue antibiotic; hypoxia (below normal levels of oxygen)-chest x-ray show questionable pulmonary edema (fluid accumulates in lung tissue) vs interstitial pneumonitis (inflammatory lung disease affecting the connective tissue of the lung) .Hypokalemia (low blood potassium level); type 2 diabetes; CAD(coronary artery disease); hypertension (elevated blood pressure); sacral ulcer . Record review of photos the family submitted to TULIP revealed CR#1 had widespread redness to the sacral and buttocks areas. The sacral wound had a dressing with exudate from the dressing. A red, shiny area along the upper inner groin of the left hip. A portion of the female external catheter was visible in the photos. The collection canister had cloudy, frothy fluid. There were 36 photos submitted. Resident #8 Record review of Resident #8 face sheet printed 06/16/22 revealed, an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: dementia with behavioral disturbance, muscle wasting and atrophy, hypertension, depression, long term use of blood thinners and restlessness and agitation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #8's Quarterly MDS dated [DATE] revealed extensive assistance with most activities of daily living, short-term memory problem, long-term memory problem, no recall ability of the current season, location of own room, staff names and faces or that she was in a nursing home. The resident had moderately impaired cognitive skills for daily decision making, used a wheelchair and was always incontinent of both bladder and bowel. Record review of Resident #8's Care Plan printed 06/16/22 at 09:32 AM revealed, problem- at risk for falls related to cognitive impairment and generalized weakness, intervention- keep areas free of obstructions to reduce the risk of falls or injury, resident returned from ER with right arm sling placed and antibiotics for UTI. An observation on 06/16/22 at 09:43 AM revealed, Resident #8 lying in bed asleep. The resident was well groomed, well dressed, appeared in no immediate distress, and had no visible bruising and injuries. Record review of Resident # 8's Progress Notes dated 05/07/22 at 9:34 PM revealed, at around 4:15 pm, CNA resident reported that resident was lying beside her bed on the mat face down . Resident was alert and responsive to verbal stimuli. Resident obtained a small scratch to her outer right eyebrow . denies pain. Record review of Resident #8's Progress Notes dated 05/08/22 at 08:05 AM revealed, correction: incident occurred at 01:45 Pm on 05/07/22. Record review of Resident #8's Progress Notes dated 05/08/22 at 09:34 AM revealed, Resident noted to be favoring her right shoulder. Bruising to right shoulder and upper arm noted this morning post fall. Resident able to mover her fingers and elbow but is complaining of pain to her right upper should. Called Provider, awaiting on return call. Record review of Resident #8's Progress Notes dated 05/08/22 at 09:43 AM revealed, NP returned call, informed her that resident had a fall yesterday with no apparent injuries except a small scratch to the right side of her eyebrow. However today she is complaining of pain to her right shoulder and has bruising down her right shoulder to her upper arm . New order received an xray of right should and right arm to rule out fracture. Record review of Resident #8's Physician Orders from 05/07/22 to 05/09/22 revealed , no new orders received for pain medication for the residents suspected injury. Record review of Resident #8's radiology report dated 05/08/22 at 11:55 AM revealed, Impression: displaced right humeral neck fracture. Record review of Resident #8's Progress Notes dated 05/08/22 at 4:25 PM revealed, spoke with hospice nurse at 2:52 PM (over 3 hours after the results of were released) regarding x-ray results, informed x-ray shows a right shoulder fracture. New order received to send resident to urgent care for treatment of the fracture. Record review of Resident #8's Progress Notes dated 05/08/22 at 5:12 PM (over 2 hours after the order was given to send the resident out and 5 hours after the results of the fracture was released) revealed, ambulance here to transport the resident to the hospital ER for evaluation and treatment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 06/15/22 at 04:35 PM, the DON said once an order was placed to send a resident to the hospital, they should be sent out quickly. If the scheduled transport did not arrive promptly, the staff should call 911. She said residents should not wait for up to 1 hour to be transported to the hospital. In an interview on 06/16/22 at 11:06 the MD said, any findings of acute fracture require the resident to be sent out to the hospital in a timely manner and without approval from the NP/MD because his providers could not handle orthopedic issues. In an interview on 06/16/22 at 01:32 PM, the Administrator said that nursing staff were expected to act on providers orders to send residents in a timely fashion, and it should take no longer than 30-45minutes from the order being given to the resident leaving the facility. He said it was not appropriate for Resident #8 to wait for almost 2 hours to leave for the hospital after the order was given. The Administrator said that failure to send residents out to the hospital in a timely fashion, placed residents at risk of delayed treatment and pain. Record review of the facility's policy and procedure titled Patient Care Management System 1 - Skin, Cantex Continuing Care Network, April 2022 read in part: .1. A head-to-toe skin assessment must be completed and documented by the Admitting Nurse upon admission .of every patient 2. The treatment nurse/designee must complete a head-to-toe assessment and document in the EMR to validate the findings of the initial skin assessment 3. A Braden Scale must be completed the day of admission .once weekly for a minimum of four weeks and quarterly thereafter .7. A wound assessment must be completed by the treatment nurse/designee and a narrative of each site must be documented weekly for any pressure injury and non-pressure skin condition, including but not limited to Arterial Ulcers, Diabetic Neuropathy Ulcers, Venous Insufficiency Ulcers, Bruises, Skin Tears, and surgical Wounds .9. A certified Nurse Aide will notify the treatment nurse or charge nurse of any newly identified skin issues .13. Timely and appropriate incontinent care will be provided to all incontinent Patients. The Facility must ensure that all licensed staff and nurse aides are consistently in-serviced on the provision of proper incontinent care Record review of the facility policy and procedure titled Patient Care Management System 12, Assessments, Cantex Continuing Care Network dated November 2017 read in part .4. A Baseline, Person-centered Plan of Care for each patient that includes the instructions needed to provide effective and person-centered care of the patient that meet professional standards of quality care. Record review of facility policy and procedure titled Patient Care Management System 18 - Interact, Cantex Continuing Care Network dated March 2016 read in part .1. The Stop and Watch Early Warning Tool must be initiated upon the first signs of a Patient presenting with a change in condition and the nurse notified immediately. 2. A Care Path Form .must be used as a guide when a Patient presents with a change in condition. 3. A Situation, Background, Assessment and Request (SBAR) Communication Form and Progress Note must be completed upon a Patient's change in condition .The SBAR Communication Form can replace a nurse's note The staff in-service dated on 4/15/2022 at 2:00 PM included change in condition and was conducted by the DON. Record review of the facility policy and procedure titled Bath-Bed, Nursing Policy & Procedure, Personal Care-Section 11; Cantex Continuing Care Network March 2013 read in part .Responsibility: Licensed Nurse and Nursing Assistant, Purpose: To cleanse, refresh, and soothe the Patient; to stimulate circulation and to inspect the body .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41392 Based on observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for four residents (Resident #1, #2, #3 and #4) of four residents reviewed for incontinent care. 1. CNA A failed to perform hand hygiene during incontinent care for Resident #1 and #2. 2. CNA A failed to properly cleanse Resident #3's buttocks area completely during incontinent care. 3. CNA B failed to perform hand hygiene during incontinent care for Resident #4. 4. CNA B failed to cleanse between labia folds and proximal end of urinary foley catheter during female incontinent care for Resident #4. This failure could place residents at risk for discomfort, skin breakdown, skin infection, cross contamination, and urinary tract infections. Findings included: Resident #1: Record review of Resident #1 face sheet printed on 06/02/2022 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: hemiplegia, dysphagia, stroke, congestive heart failure, Type 2 diabetes, history of fracture to left lower leg, hypertension, morbid obesity, muscle weakness, history of urinary tract infection, history of vaginal yeast infection and recent history of scabies. Record review of the significant change Minimum Data Set (MDS) resident assessment date completed on 5/04/2022 revealed Resident #1 had a BIMS score of 9 indicating she had moderate cognitive impairment. Resident #1 was always incontinent of urine and bowel and required total assistance of two staff for all ADL care. Record review of Resident #1's care plan effective date 12/11/2018 to present revealed in part; -Problems: Resident #1 is diabetic and at risk for frequent infections -Interventions included: Monitor for skin changes, redness, circulatory problems, breakdown -Problem Resident #1 is at risk for skin breakdown related to diabetes and hemiplegia -Interventions included: Monitor for incontinence, every 2 hours and as needed, change promptly. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Problems: Resident needed staff assistance with ADLs -Interventions included: set up, assist, give shower, shave, oral, hair, nail care scheduled and prn; assist with ADLs as needed. Further review of Resident #1's care plan revealed no care plan or interventions related to incontinent care. Observation and interview on 5/18/2022 at 2:33 PM revealed, Resident #1 was in bed. CNA A was performing incontinent care, assisted by CNA D. CNA A had clean gloves on. The needed supplies were on the overbed table. CNA A wiped the left groin, then wiped the right groin and passed over the vagina. Resident #1 was turned to her left side. CNA A wiped the perianal area from vagina to rectum and removed the feces. The dressing on the sacrum was loose and was stained brown on one edge. CNA A removed the soiled brief. CNA A touched clean brief and positioned beneath the resident, fastened the brief, touched the gown and the bed linen. CNA A touched Resident #1's personal items on the overbed table. CNA A removed gloves and walked out of room saying she would return and would let the nurse know about the soiled dressing. CNA A said when using cleansing wipes, they can be folded and use clean side to clean another area. CNA A said she would not clean from groin to vagina in order to prevent spreading infection, and that she would change gloves when they are visibly dirty. CNA A said the gloves were dirty after cleaning the resident and she should have removed them hand sanitized and put on clean gloves. CNA A said this is to prevent cross-contamination and for infection control. CNA A said she realized gloves should have been changed and hand sanitized before touching items on the bedside table because, the gloves were dirty and used when cleaning feces. CNA A said she did spread the labia and cleaned the area in the beginning. Interview on 5/18/2022 at 2:53 PM the DON stated when performing incontinent care, she would hand sanitize, put on clean gloves and start with wipes, making sure not to go from back to front or reuse wipe over another area. She would hand sanitize between dirty and clean procedure. She said always hand sanitize put on clean gloves and then apply barrier cream. Typically, she would teach CNAs to get another clean wipe so not to bring contaminants into the new area. This is to prevent infection. DON's plan was to in-service the staff, especially the 2 CNAs who performed incontinent care for Resident #1. The DON said a big in-service including incontinent care was done within the last month. So she was surprised this happened. Interview on 5/18/2022 at 3:57 PM with CNA A revealed she did not wash her hands before leaving Resident #1's room because she was nervous. Resident #2: Record review of Resident #2 face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: stroke, hypertension, epilepsy, hemiplegia, dysphagia, repeated falls and UTI. Record review of the Annual Minimum Data Set (MDS) resident assessment date completed on 10/22/2021 revealed Resident #2 had no speech, rarely made self-understood and usually understood others. She had long-term memory problems and her cognitive skills for daily decision making was moderately impaired. She was always incontinent of urine and bowel and totally dependent on one staff assist for all ADL care. Record review of Resident #2's care plan effective date 06/24/2016 to present revealed in part; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Problems: Resident #2 is always incontinent of bowel movement and bladder. -Interventions included: apply moisture barrier to buttocks, check for incontinence, clean and dry skin if wet or soiled, document when incontinent, perform complete skin assessment, use pads/briefs to manage incontinence -Problems: Resident #2 is at risk for skin breakdown, related to impaired mobility and incontinence -Interventions included: check skin for redness, skin tears, pressure areas, report any signs of skin breakdown. Observation and interview on 5/29/2022 at 6:30 PM, CNA A prepared a clean work area for incontinent care for Resident #2. CNA A donned clean gloves and transferred Resident #2 from the wheelchair to the bed. She removed Resident #2's pants, unfastened the adult brief. There was a strong urine odor and the brief was supersaturated with urine. CNA A used cleansing wipe to the left groin a second wipe to the right groin. CNA A spread the labia and with a new cleansing wipe she cleansed the vulva. With a clean wipe she cleansed the buttocks and perianal area. She then doffed the gloves, donned clean gloves, positioned, and secured the clean adult brief and doffed gloves. She said the pants were clean and will assist resident to put them on. Surveyor asked if the pants were wet or not. CNA A said they were not wet. She then donned clean gloves and closely inspected the pants and said they were wet. CNA A got new dry pants from the closet and assisted the resident. She was just about to transfer Resident #2 back into the wheelchair. The Surveyor asked about the possible wet wheelchair pad. CNA A said she usually does wipe down the wheelchair. She wiped it down with clean cleansing wipes transferred the resident into the wheelchair. CNA A gathered the garbage, left the room, and walked to the dirty utility room then sanitized her hands using dispenser outside the dirty utility room. She said she should have sanitized between glove changes to help prevent cross contamination. Resident #3: Record review of Resident #3 face sheet printed on 06/02/2022 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: hypertension, stroke, heart disease and mental disorder. Record review of the Admission Minimum Data Set (MDS) resident assessment date completed on 04/25/2022 revealed Resident #3 was always incontinent of urine and bowel and totally dependent on one staff assist for all ADL care. Record review of Resident #3's care plan effective 4/7/2022 to present date revealed in part: -Problems: Resident #3 required extensive to total assist with ADLs and functional mobility status. -Interventions included: set up, assist, give shower, shave, oral, hair, nail care scheduled and prn; assist with ADLs as needed. Problems: Resident #3 was at risk for pressure ulcer development due to risk factors as identified on the Braden Scale (a tool to measure the risk of developing pressure ulcers) (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions included: turn every 2 hours, pressure reduction mattress, utilize draw sheet, skin protocols, barrier cream. - Further review of Resident #1's care plan revealed no care plan or interventions related to incontinent care. Observation and interview on 5/29/2022 at 7:15 PM, CNA A set up a clean work area, donned clean gloves, assisted Resident #3 in removing her pajama bottom, unfastened the brief. She took a cleansing wipe to the left groin, folded wipe, and cleansed right groin. CNA A spread Resident #3's labia and with a clean wipe cleansed the vulva area once. CNA A turned resident to her right side. Observed the skin on buttocks to be a deep maroon color and the area on the left buttocks had a white patch. The family stated this was the start of a pressure sore. CNA A cleansed the perianal area and with a new wipe and cleansed the right buttocks circling around the white patch. CNA A cleansed the left buttocks with a fresh wipe. The family applied a cream and moisturizer to the buttocks. CNA A removed the gloves, washed hands at the sink in the room. CNA A donned clean gloves, positioned and secured the adult brief, assisted Resident #3 to put on the pajama bottoms and adjusted bed linens. CNA A put away clean supplies, gathered the trash, doffed the gloves, walked out of the room to the dirty utility room. The hand sanitizer dispenser outside the dirty utility room was empty. CNA A washed hands at the sink in the small kitchenette adjacent to the dirty utility room. CNA A stated she cleansed the groin area before the vulva area because the groin is a clean area and did not want to cross contaminate from vulva to groin. CNA A stated this is how she was taught in school and did not know what the facility policy and procedure was for incontinent care. CNA A stated she did cleanse the white patch on Resident #3's buttocks. CNA A stated she did not hand sanitize prior to entering the resident room because she had just sanitized outside the dirty utility room. She stated sometimes there would not be any soap in the resident bathrooms, so she sanitized her hands after taking the trash to the dirty utility room. Interview on 5/29/2022 at 8:00 PM, LVN D stated hand hygiene is always done prior to entering the resident room for infection control. She said she will work from the groin to one side of the vulva and then the other side of the vulva with a new cleansing wipe each time. When done cleaning the front area she would perform hand hygiene, don clean gloves, and then clean the perianal area from front to back. With a new wipe she would clean the buttocks and surrounding skin. She would doff gloves, wash hands, don clean gloves then position the clean brief and bed linens. She would wash hands, gather trash, use a glove to touch trash and carry to the dirty utility room then sanitize hands. Interview on 6/02/2022 at 12:45 PM, LVN D stated the reason for performing hand hygiene during incontinent care, between glove changes, before starting the care and before exiting the resident room was to help prevent the spread of infection. She stated the wheelchairs are cleaned on night shift and she had tried to educate the night staff about cleaning dirty or wet wheelchairs, when residents are visibly soiled and if the pants were soaked. Therapy or central supply was responsible to inspect the cushions if soiled. LVN D did not state how often cushions were inspected by therapy or central supply. It could cause wounds or skin breakdown if a resident remains seated in wet clothes and cushions. If severe enough, the resident should shower or have a bed bath. Redness to the skin on a resident's buttocks could be from sitting in urine or fecal matter and some people's skin are easily irritated. Resident #4: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's face sheet printed on 5/19/2022 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: type 2 diabetes, metabolic encephalopathy (chemicals adversely affecting brain function), kidney stones, COPD, PVD, pulmonary embolism, excess urine accumulating in the kidney, UTI, hypertension and open wound of right buttocks. Record review of the Admission Minimum Data Set (MDS) resident assessment date completed on 05/05/2022 revealed Resident #4 had a BIMS score of 14 indicating her cognition was intact. She had a urinary catheter, and she was always incontinent of bowel. She required extensive assistance with one person for all ADL care. Record review of Resident #4's care plan effective date 04/28/2022 to present, revealed in part; -Problems: Resident #4 requires extensive assistance to total assistance with ADLs and functional mobility. -Interventions included: set-up, assist, give shower, shave, oral, hair, nail care on schedule and as needed. -Problems: Resident #4 was always incontinent of bowel movement. -Interventions included: apply moisture barrier to buttocks, document when incontinent. -Problems: Resident #4 is at risk for infection related to indwelling catheter -Interventions included: clean around catheter with soap and water or may use wipes as appropriate/desired by patient; keep tubing below level of bladder and fee of kinks or twists; report any signs of infection, wash hands before and after procedure. (continued on next page)

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	676357	A. Building B. Wing	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/15/2022 at 2:10 PM of incontinent care for Resident #4. CNA B assembled clean supplies on the bedside table, donned clean gloves and explained to the resident that she was going to clean her up. The foley bag had 350cc of amber urine. CNA B moved the foley bag from the lower frame of the bed and placed it on top of the bed sheet to the right of the resident's legs. She unfastened the brief. CNA B cleansed the right groin with a wipe, folded the wipe and cleansed the left groin. She assisted the resident to roll to the right side in order to change the bed linen. She removed the linen and replaced with clean linen. CNA B removed the soiled brief. Resident #4's skin on the buttocks had areas that were open and bleeding. The surrounding skin was red, excoriated, widespread from vagina, across buttocks and up to lower lumbar region. The edges of the red area on lower back was dry and flaky. CNA E entered room, washed hands at the bathroom sink and donned clean gloves and assisted CNA B. CNA B cleaned the perianal area with a wipe starting from front to back, folded the wipe and cleansed the perianal area again wiping away the feces then folded the wipe and cleansed the sacral area. CNA B removed gloves and donned clean gloves. The foley catheter anchoring device was wrapped and stuck around the foley catheter very close to the vagina area. CNA E gently removed the adhesive device from the foley catheter. The resident said ouch once. CNA B used one wipe to cleanse the lower vagina region moving from front to back, folded the wipe and cleansed the same area again. The resident said ow, you don't listen. With the same gloves CNA B applied the Calazime lotion to the buttocks and lower lumbar region then removed the gloves. CNA B started to don a new pair of gloves when CNA E reminded to wash her hands first. CNA B washed her hands then donned clean gloves, positioned the clean brief under the resident and turned resident onto her back. There was white substance visible in the folds of the vagina when the resident was turned to her back. The foley bag was moved to the left side of the resident on the bed. CNA B applied Calazime cream to inside groin areas and skin over the vulva. She removed gloves, washed hands, donned new gloves. Without first spreading the labia, CNA B cleaned the foley catheter, starting from the patient outward with a cleansing wipe. She then secured the brief: opened brief again, repositioned the catheter and secured brief again. CNA B removed Resident #4 soiled gown and dressed the resident in a clean gown. The resident was turned to her left side, a wedge placed under her back and linen adjusted. The foley tubing and bag was moved of the bed and hung on bed frame to the left and below the resident then CNA B removed gloves. Foley bag had approximately 700cc urine. Interview on 6/15/2022 at 3:00 PM CNA B stated she was taught to fold the wipes and use a second time, by the State and that this was facility policy. When asked why she did not spread the labia and clean within the folds, she stated she did spread the labia and wiped inside. When asked why she applied cream before cleaning the catheter she stated she did not want to get cream onto the catheter. When asked why she did not sanitize hands between glove changes she stated she did wash her hands three times and the reason for hand washing or hand sanitizing was for infection control. When asked, what did she do to prevent urine from backing up into the resident and help prevent a UTI she stated she made sure to straighten the catheter and tubing prior to placing it on the bed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/15/2022 at 4:22 PM, the DON was notified of Resident #4's incontinent care performed by CNA B. DON stated during peri care she preferred to use one cleansing wipe per area. She expects the nursing staff to hook the foley bag to the same side of the bed the resident is turned to so not to cross over the leg during incontinent care. The foley bag is always positioned below the patient to prevent backflow of urine and prevent infection. The foley bag and tubing should never be placed on the bed due to the risk of urine backflow into the resident. She stated to prevent infection, hand sanitizing is performed after changing gloves, any time the gloves are visibly soiled, when entering and exiting a resident room, after removing the soiled brief and prior to and after applying barrier cream. The DON stated she will start staff in-services specifically on UTI prevention and that spot checks are done by the nurses to watch how the CNAs are performing incontinent care. She stated that once a day spot checks will be needed. Record review of CNA A's staff competency check list for incontinent care dated 4/26/2022 and CNA B's staff competency check list for incontinent care dated 5/20/2022, read in part: .3. Assemble equipment and supplies on bedside .4. Wash hands and apply gloves .6. Assist patient to supine position and remove soiled clothing and/or brief .7. Remove gloves, sanitize hands, and apply new gloves .Female Perineal Care .2. Wash, beginning from center of abdomen and clean outwards from front to side. Use new wipe per area .3. Wash from front towards rectum .using clean stroke. Never wipe back and forth from the back to the top .4. Separate labia with and to expose urethral meatus. Use one stroke method to clean front to back. 5. Wash labia major and skin folds 6. Cleanse inside of the first groin area downward from top to bottom, then get a new wipe and cleanse the other groin area .7. If catheter present, stabilize the catheter, then gently wipe the catheter tubing with new wipe from the meatus outward .10. With new wipe, cleanse the entire buttock area and surrounding hip area. Turn over surface of wipe to cleanse other side of buttock .11. Wash/sanitize hands. Apply clean gloves 12. Position brief under patient. Apply barrier cream to perineal and buttock area . fasten clean brief .13 wash hands. Record review of the facility policy and procedure titled Handwashing, Cantex Continuing Care Network, revised March 2019 read in part: Guidelines, Standards of Practice/Hand washing - Hand washing is the single most important means of preventing the spread of infection After Patient contact wash hands with soap and running water May use hand sanitizing gel in place of soap and water. Record review of the facility policy and procedure titled Catheter Care, Cantex Continuing Care Network, updated March 2019 read in part: Responsibility - Licensed Nurse and Nursing Assistant. Purpose - To prevent infection and to reduce irritation Procedure - wash your hands, gather equipment, and take to bedside .put on gloves, cleanse perineal area with warm wash towel. Wash perineum well with soap and warm water, taking care to wash from front to back. May use wipes in place of soap and water .Cleanse area at catheter insertion well .pat dry gently with clean towel .discard disposable equipment properly. Ensure leg strap in place to secure tubing .wash your hands . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy and procedure titled Perineal Care Protocol, Cantex Continuing Care Network, February 2022 read in part: .Cleansing the perineal area between showers or baths help prevent irritation, infection and skin breakdown as well as keeping the patient comfortable Assemble equipment and supplies on bedside .will need .hand sanitizer .Wash hands; apply gloves .remove soiled clothing and/or brief, if needed clean soiled areas first by wiping off fecal material with wipes. Remove gloves, sanitize hands, and apply new gloves Using a new wipe, wash, beginning from center of abdomen, and clean outwards from front to side separate labia with hand to expose urethral meatus. Use one stroke method to clean front to back. Wash labia major and skin folds Using a wipe, cleanse the inside of the first groin area then get a new wipe and cleanse the other groin area .Ask patient .assume side lying position .Using a new wipe, wash from vagina toward rectum with one stroke, front to back, repeat if necessary with a wipe as all feces must be cleaned off. With new wipe, cleanse the entire buttock area and surrounding hip area. Turn over surface of wipe to cleanse other side of buttock. Wash/sanitize hands. Apply clean gloves .Report any skin concerns to Charge Nurse .

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F 0777 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview, and record review the facility failed to promptly notify the ordering physician of results that fell outside of clinical procedures for notification of the ordering physician orders for 2 of 10 resident (Resident #7, Resident #8) reviewed for diagnostic services. - The facility failed to timely report Resident #7's radiology findings of an acute left hip fracture resulting in a delay of surgical treatment in the hospital by over 32 hrs. - The facility failed to timely report Resident #8's radiology findings of resulting in a delay of treatment These failures could place residents at risk for delayed identification and treatment of undiagnosed illnesses, hospitalization , pain, and suffering. Findings Include: Resident #7 Record review of Resident #7's face sheet revealed, an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: scoliosis , lower back pain, depression and unspecified fracture. Record review of Resident #7's Admission MDS dated [DATE] revealed, moderately impaired vision with the use of corrective lenses, short term memory problem, long-term memory problem, moderately impaired cognitive skills for daily decision making and extensive assistance with most activities of daily living, ambulation with a walker, history of a fall with fracture in the 6 months prior to admission. Record review of Resident #7's Care Plan dated 06/15/22 revealed, Problem- as risk for falls related to history of falls, intervention- keep areas free of obstruction to reduce the risk of falls or injury, non-skid footwear, call bell/light within easy reach. An observation on 04/27/22 at 10:40 AM revealed, Resident #7 walking in the hallway with non-skid socks on. The resident appeared well groomed, well dressed in no immediate distress, he had no visible injuries. Resident #7 was unable to be interviewed due to limited English proficiency. Record review of Resident #7's Progress Notes dated 04/12/22 at 03:05 PM revealed, CNA reported to nurse that patient was on the floor. Patient's vitals were within range for patient. However, patient had some pain to his left knee, NP notified and ordered a 2-view x-ray of the left knee due to fall and complaints of pain Patient was assisted back into bed by CNA and nurse. Record review of Resident #7's Radiology Report dated 04/13/22 at 01:30 AM revealed, Left Femur X-ray Impression: Acute Left Hip Fracture. (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #7's Progress Notes dated 04/14/22 at 10:45 AM (over 24 hours after a fracture was identified) signed by NP #2 revealed, x-ray of left knee and left femur reviewed on 04/14/22, resulted on 04/13/22. Send patient to hospital for Ortho evaluation . NP #2 ordered to send the patient to ER for evaluation and treatment. Record review of Resident #7's Progress Notes dated 04/14/22 at 11:10 AM revealed, Xray results received from patient's fall. There is an acute fracture of the left hip Patient is alert, now in cafe. NP #2 ordered to send the patient to ER for evaluation and treatment. Record review of Resident #7's EHR revealed, no pain assessments or head to toe assessment was documented between 04/12/22 and 04/14/22. Record review of Resident #7's Hospital Procedure Notes dated 04/15/22 revealed, Procedure Performed: left hip intramedullary nailing, a surgery to repair a broken bone and keep it stable by inserting a permanent nail or rod into the center of the bone. Resident #8 Record review of Resident #8 face sheet printed 06/16/22 revealed, an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: dementia with behavioral disturbance, muscle wasting and atrophy, hypertension, depression, long term use of blood thinners and restlessness and agitation. Record review of Resident #8's Quarterly MDS dated [DATE] revealed extensive assistance with most activities of daily living, short-term memory problem, long-term memory problem, no recall ability of the current season, location of own room, staff names and faces or that she was in a nursing home. The resident had moderately impaired cognitive skills for daily decision making, used a wheelchair and was always incontinent of both bladder and bowel. Record review of Resident #8's Care Plan printed 06/16/22 at 09:32 AM revealed, problem- at risk for falls related to cognitive impairment and generalized weakness, intervention- keep areas free of obstructions to reduce the risk of falls or injury, resident returned from ER with right arm sling placed and antibiotics for UTI. An observation on 06/16/22 at 09:43 AM revealed, Resident #8 lying in bed asleep. The resident was well groomed, well dressed, appeared in no immediate distress, and had no visible bruising and injuries. Record review of Resident # 8's Progress Notes dated 05/07/22 at 9:34 PM revealed, at around 4:15 pm, CNA resident reported that resident was lying beside her bed on the mat face down . Resident was alert and responsive to verbal stimuli. Resident obtained a small scratch to her outer right eyebrow . denied pain. Record review of Resident #8's Progress Notes dated 05/08/22 at 08:05 AM revealed, correction: incident occurred at 01:45 Pm on 05/07/22. (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #8's Progress Notes dated 05/08/22 at 09:34 AM revealed, Resident noted to be favoring her right shoulder. Bruising to right shoulder and upper arm noted this morning post fall. Resident able to move her fingers and elbow but is complained of pain to her right upper shoulder. Called Provider, awaiting on return call. Record review of Resident #8's Progress Notes dated 05/08/22 at 09:43 AM revealed, NP returned call, informed her that resident had a fall yesterday with no apparent injuries except a small scratch to the right side of her eyebrow. However today she is complaining of pain to her right shoulder and has bruising down her right shoulder to her upper arm . New order received an x-ray of right shoulder and right arm to rule out fracture. Record review of Resident #8's Physician Orders revealed, no new orders received for pain medication for the residents suspected injury. Record review of Resident #8's radiology report dated 05/08/22 at 11:55 AM revealed, Impression: displaced right humeral neck fracture. Record review of Resident #8's Progress Notes dated 05/08/22 at 4:25 PM revealed, spoke with hospice nurse at 2:52 PM (over 3 hours after the results of were released) regarding x-ray results, informed x-ray shows a right shoulder fracture. New order received to send resident to urgent care for treatment of the fracture. Record review of Resident #8's Progress Notes dated 05/08/22 at 5:12 PM (over 2 hours after the order was given to send the resident out and 5 hours after the results of the fracture was released) revealed, ambulance here to transport the resident to the hospital ER for evaluation and treatment. In an interview on 06/15/22 at 04:35 PM, the DON said once an order is placed to send a resident to the hospital, they should be sent out quickly and if the scheduled transport did not arrive promptly the staff should call 911. She said residents should not wait for up to 1 hour to be transported to the hospital In an interview on 06/16/22 at 11:06 the MD said, any findings of acute fracture required the resident to be sent out to the hospital in a timely manner and without approval from the NP/MD because his providers could not handle orthopedic issues. In an interview on 06/15/22 at 02:26 PM, NP #3 said it was the nursing staff's responsibility to notify the NP/MD of any acute fractures and once identified resident's must be sent out immediately because they need assessment from an orthopedic specialist. She said that she was not informed of Resident #7's acute fracture that was identified on 04/13/22 but she happened to review his lab records on 04/14/22 and immediately sent the resident out to the hospital. (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	In an interview on 06/15/22 at 04:35 PM, the DON said that if a lab or x-ray service identifies an acute fracture or critical labs, a fax is sent to the facility and they are also called. She said the nursing staff have access to the labs at the nursing stations from the providers portal, and it was every nurse's responsibility to check the fax and the portals multiple times during their shift. The DON said if there was an outstanding lab, nursing staff should continuously check for the results. She said she did not know why the facility had a delayed response to Resident #7's acute fracture, but it was not appropriate for his treatment to be delayed by over 24 hours. The DON said she was unaware of the over 3 hour delay in notification of Resident #8's acute fracture and did not know why the findings were not communicated immediately to the NP. She could not identify who was responsible for following up on Resident #7 and Resident #8's pending lab results or account for the delayed physician notification. In an interview on 06/16/22 at 01:32 PM, the Administrator said significant x-ray findings should be reported to the NP/MD immediately and failure to report significant x-ray findings such as acute fractures could place residents at risk of pain, adverse events, and delayed treatment. Record review of the facility policy titled Physician Notification revised 03/2019 revealed, the types of condition which arise frequently are listed . laboratory values. It is the responsibility of the nursing staff to observe the change, make an assessment, and notify the physician as indicated based on the assessment. The Physician, PA, NP, or clinical nurse specialist is to be promptly notified of the results of the radiology, lab and other diagnostic tests ordered.

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observation, interview, and record review, the facility did not maintain an infection prevention program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 4 of 7 residents (Resident #1, #2, #3, and #4) reviewed for infection control. -CNA A failed to perform hand hygiene during incontinent care for Resident #1 and Resident #2. -The facility failed to provide incontinent care for Resident #2 for more than 2 hours. Resident #2's brief was saturated with urine and soaked through her pants and onto the wheelchair pad. -CNA A failed to cleanse Resident #3's buttocks area completely by not washing off the white cream that was over a reddened area. -CNA B failed to perform hand hygiene during incontinent care for Resident #4 - CNA B failed to cleanse between labia folds and proximal end of the urinary catheter during female incontinent care for Resident #4. These failures could place the remaining 77 residents who required incontinent care at risk for cross contamination, infection, delay in treatment and hospitalization . Findings included: Resident #1: Record review of Resident #1 face sheet printed on 06/02/2022 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: hemiplegia, dysphagia, stroke, congestive heart failure, Type 2 diabetes, history of fracture to left lower leg, hypertension, morbid obesity, muscle weakness, history of urinary tract infection, history of vaginal yeast infection and recent history of scabies. Record review of the significant change Minimum Data Set (MDS) resident assessment date completed on 5/04/2022 revealed Resident #1 had a BIMS score of 9 indicating she had moderate cognitive impairment. Resident #1 required total assistance of two staff for her bed mobility and transfers. She required total assistance of one staff person for dressing, toilet use and personal hygiene. She was always incontinent of urine and bowel. Record review of Resident #1's care plan effective date 12/11/2018 to present revealed in part; -Problems: Resident #1 is diabetic and at risk for frequent infections -Interventions included: Monitor for skin changes, redness, circulatory problems, breakdown, report to MD, RP. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	-Problem Resident #1 is at risk for skin breakdown . -Interventions included: Monitor for incontinence, every 2hours and as needed, change promptly. Apply moisturizing lotion, give meds per order, use non-irritating soaps. -Problems: Pressure ulcer prevention -Interventions included: turn ever 2hours, skin protocols, barrier cream. Observation and interview on 5/18/2022 at 2:33 PM, Resident #1 was in bed. CNA A was performing incontinent care, assisted by CNA D. CNA A had clean gloves on and the needed supplies were on the overbed table. CNA A wiped the left groin, then wiped the right groin and passed over the vagina. Resident #1was turned to her left side. CNA A wiped the perianal area from vagina to rectum and removed the feces. The dressing on the sacrum was loose and was stained brown on one edge. CNA A removed the soiled brief and placed in trash bag. CNA A touched clean brief and positioned beneath Resident #1 fastened the brief and touched gown and bed linen. CNA A then touched Resident #1's personal items on the overbed table. CNA A removed gloves and walked out of room saying she would return and would let the nurse know about the soiled dressing. CNA A said when using cleansing wipes, can be folded and use clean side to clean another area. CNA A said she would not clean from groin to vagina in order to prevent spreading infection, and that she would change gloves when they are visibly dirty. CNA A said the gloves are dirty after cleaning the resident and she should have removed them hand sanitized and put on clean gloves. CNA A said this is to prevent cross-contamination and for infection control. CNA A said she realized gloves should have been changed and hand sanitized before touching items on the bedside table because, the gloves were dirty and used when cleaning feces. CNA A said she did spread the labia and cleaned area in the beginning. Interview on 5/18/2022 at 2:53 PM the DON stated when performing incontinent care, she would hand sanitize, put on clean gloves and start with wipes, making sure not to go from back to front or reuse wipe over another area. She would hand sanitize between dirty and clean procedure. She said always hand sanitize don clean gloves and then apply barrier cream. Typically, she would teach CNAs to get another clean wipe so not to bring contaminants into the new area. This is to prevent infection. DON plan was to in-service the staff, especially the 2 CNAs who performed incontinent care for Resident #1. DON said a big in-service including incontinent care was done within the last month, so she was surprised this happened. Interview on 5/18/2022 at 3:57 PM, CNA A she didn't wash her hands before leaving Resident#1 room because she was nervous. Resident #2: Record review of Resident #2 face sheet printed on 06/02/2022 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: stroke, hypertension, epilepsy, hemiplegia, dysphagia, repeated falls and UTI. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Record review of the Annual Minimum Data Set (MDS) resident assessment date completed on 10/22/2021 revealed Resident #2 had no speech, rarely made self-understood and usually understood others. She had long-term memory problems and her cognitive skills for daily decision making was moderately impaired. She was totally dependent on one staff for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. She used a wheelchair for mobility. She was always incontinent of urine and bowel. Record review of Resident #2's care plan effective date 06/24/2016 to present revealed in part; -Problems: Resident #2 is at risk for falls related to impaired mobility -Interventions included: respond promptly to calls for assistance to the toilet -Problems: Resident #2 is always incontinent of bowel movement and bladder. -Interventions included: apply moisture barrier to buttocks, check for incontinence, clean and dry skin if wet or soiled, document when incontinent, perform complete skin assessment, use pads/briefs to manage incontinence -Problems: Resident #2 is at risk for skin breakdown, related to impaired mobility and incontinence -Interventions included: check skin for redness, skin tears, pressure areas, report any signs of skin breakdown. Record review of Resident #2's June 2022 physician orders revealed an order Proactive Health Check to determine early changes in order to proactively monitor and treat as appropriate, start date 08/09/2020. Weekly head-to-toe (skin assessment), start date 02/03/2022. Observation and interview on 5/29/2022 at 6:00 PM Resident #2 was sitting in a wheelchair and visiting with family in her room. The Family said the staff did not check on her often enough. The family had been at the facility since around 3:30 PM and stated no one has come by to check her. The family stated they have in the past seen the staff change Resident #2 and put her right back into the wet chair and that was just not right. The family assisted Resident #2 to a standing position. Her pants had large dark wet stain. The pad on the wheelchair was wet. The family turned the call light on and requested staff to change Resident #2. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 5/29/2022 at 6:30 PM, CNA A prepared a clean work area for incontinent care for Resident #2. CNA A donned clean gloves and transferred Resident #2 from the wheelchair to the bed. She removed Resident #2's pants and unfastened the adult brief. There was a strong urine odor and the brief was supersaturated with urine. CNA A used cleansing wipe to the left groin a second wipe to the right groin. CNA A spread the labia and with a new cleansing wipe she cleansed the vulva. Resident assisted to turn onto her left side. With a clean wipe she cleansed the buttocks, perianal area. She then doffed the gloves, donned clean gloves, positioned, and secured the clean adult brief and doffed gloves. She said the pants were clean and will assist resident to put them on. Surveyor asked if the pants were wet or not. CNA A said they were not. She then donned clean gloves and closely inspected the pants and said they were wet. CNA A got dry pants from the closet and assisted the resident with putting them on. She was just about to transfer Resident #2 back into the wheelchair. The Surveyor asked about the possible wet wheelchair pad. CNA A said she usually wipes down the wheelchair. She wiped it down with clean cleansing wipes then transferred the resident into the wheelchair. CNA A gathered the garbage, left the room, and walked to the dirty utility room, she sanitized her hands using dispenser outside the dirty utility room. She said she should have sanitized between glove changes to help prevent cross contamination. Record review of Resident #2 nursing clinical notes written by LVN D on 06/03/2022 at 3:41 PM read in part . During head-to-toe skin assessment .incontinent care was provided the patient does have a foul urine odor. Waiting on new orders . Record review of Resident #2 nursing clinical notes written by LVN D on 06/08/2022 at 8:49 AM read in part . Patient's urine results are in. Her urine was cloudy and she had moderate leukocyte esterase (white blood cells in the urine indicating possible infection) .notified NP. No new orders at the time. Record review of Resident #2's nursing clinical notes written by LVN D on 06/10/2022 at 9:23 AM read in part .Per NP, patient to take Macrobid 100 mg via PEG BID for 7 days for UTI . Resident #3: Record review of Resident #3 face sheet printed on 06/02/2022 revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: hypertension, stroke, heart disease and mental disorder. Record review of the Admission Minimum Data Set (MDS) resident assessment date completed on 04/25/2022 revealed Resident #3 had unclear speech, usually made self-understood and usually understood others. She was totally dependent on one staff for bed mobility, transfers, dressing, toilet use and personal hygiene. She used a wheelchair for mobility. She was always incontinent of urine and bowel. Record review of Resident #3's care plan effective date 04/07/2022 to present, revealed in part; -Problems: Resident #3 is at risk for falls related to right sided hemiparesis (weakness from a stroke) and dementia. -Interventions included: respond promptly to calls for assistance to the toilet (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	-Problems: Resident #3 is at risk for pressure ulcer development due to risk factors identified in the Braden Scale. -Interventions included: turn every 2 hours, skin protocols, barrier cream. Record review of Resident #3's June 2022 physician orders revealed an order Proactive Health Check to determine early changes in order to proactively monitor and treat as appropriate, start date 04/06/2022. Weekly head-to-toe (skin assessment), start date 04/06/2022. Wound treatment - Barrier cream, apply after each incontinent episode starting 05/29/2022. Observation and interview on 5/29/2022 at 7:15 PM, Resident #3's family member came to the nurse station asking CNA A to change Resident #3 as it had been several hours since anyone changed her. CNA A went into Resident #3 room and began to set up a clean work area, donned clean gloves, assisted Resident #3 to remove her pajama bottom, unfastened the brief, cleansing wipe to the left groin, folded wipe, and cleansed right groin. CNA A spread Resident #3's labia and with a clean wipe cleansed the vulva are once. CNA A turned resident to her right side. Observed the skin on buttocks to be a deep maroon color and the area on the left buttocks had a white patch. The family stated this was the start of a pressure sore. CNA A cleansed the perianal area and with a new wipe she cleansed the right buttocks circling around the white patch. CNA A cleansed the left buttocks with a fresh wipe. The family applied a cream and moisturizer. CNA A removed the gloves, washed hands at the sink in the room. CNA A donned clean gloves, positioned and secured the adult brief. She assisted Resident #3 to put on the pajama bottoms and adjusted bed linens. CNA A put away clean supplies, gathered the trash, doffed the gloves, walled out of the room to the dirty utility room. The hand sanitizer dispenser outside the dirty utility room was empty. CNA A washed hands at the sink in the small kitchenette. CNA A stated she cleansed the groin area before the vulva area because the groin is a clean area and did not want to cross contaminate from vulva to groin. CNA A stated this is how she was taught in school and did not know what the facility policy and procedure was. CNA A stated she did cleanse the white patch on Resident #3's buttocks. CNA A stated she did not hand sanitize prior to entering the resident room because she had just sanitized when she was outside the dirty utility room. She stated sometimes there would not be any soap in the resident bathrooms, so she sanitizes her hands after taking the trash to the dirty utility room. Interview on 5/29/2022 at 8:00 PM, LVN D stated hand hygiene is always done prior to entering the resident room for infection control and she expected the nursing staff to do this. She said she would work from the groin to one side of the vulva and then the other side of the vulva with a new cleansing wipe each time. When done cleaning the front area she would perform hand hygiene, don clean gloves, and then clean the perianal area from front to back. With a new wipe she would clean the buttocks and surrounding skin. She would doff gloves, wash hands, don clean gloves then position the clean brief and bed linens. She would wash hands, gather trash, use a glove to touch trash and carry to the dirty utility room then sanitize hands. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/02/2022 at 12:45 PM, LVN D stated barrier cream should be applied after each incontinent episode for preventative measure to serve as a barrier to protect skin from breakdown. She stated that residents should be checked for incontinence typically every 2 hours depending on the resident. It works out to every hour when the nurses are also checking every 2 hours. She stated the reason for performing hand hygiene during incontinent care, between glove changes, before starting the care and before exiting the resident room is to help prevent the spread of infection. She stated she tries to educate the night staff about cleaning dirty or wet wheelchairs and when the resident is visibly soiled if the pants are soaked. Therapy or central supply inspect the cushions if soiled. LVN D did not state how often cushions were inspected by therapy or central supply. It could cause wounds or skin breakdown if a resident remains seated in wet clothes and cushions. If severe enough the resident should shower or have a bed bath. Redness to the skin on a resident's buttocks could be from sitting in urine or fecal matter and some people's skin are easily irritated. Resident #4: Record review of Resident #4's face sheet printed on 5/19/2022 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: type 2 diabetes, metabolic encephalopathy (chemicals adversely affecting brain function), kidney stones, COPD, PVD, pulmonary embolism, excess urine accumulating in the kidney, UTI, hypertension and open wound of right buttocks. Record review of the Admission Minimum Data Set (MDS) resident assessment date completed on 05/05/2022 revealed Resident #4 had a BIMS score of 14 indicating her cognition was intact. She required extensive assistance with one person for bed mobility, transfers, dressing, toilet use and personal hygiene. She used a wheelchair for mobility. She had a urinary catheter, and she was always incontinent of bowel. Record review of Resident #4's care plan effective date 04/28/2022 to present, revealed in part; -Problems: Resident #4 requires extensive assistance to total assistance with ADLs and functional mobility. -Interventions included: set-up, assist, give shower, shave, oral, hair, nail care on schedule and as needed. -Problems: Resident #4 is at risk for skin breakdown related to incontinence, impaired mobility, fragile skin, diabetes. -Interventions included: Monitor for incontinence every 2 hours and as needed, change promptly, apply moisturizing lotion, monitor for skin breakdown and report to MD, assess skin weekly and record findings, turn, and reposition every 2 hours, use non-irritating soaps -Problems: Resident #4 stage 2 pressure ulcer to buttocks. -Interventions included: check for incontinence, clean and dry skin if wet or soiled, perform complete skin assessment and record, provide care according to the protocol for stage 1 pressure ulcer -Problems: Resident #4 was totally dependent on the staff. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	-Interventions included: bathe/shower 3 times a weekly. -Problems: Resident #4 was always incontinent of bowel movement. -Interventions included: apply moisture barrier to buttocks, document when incontinent. -Problems: Resident #4 has history of UTI within the last 30days (effective 5/18/2022) -Interventions included: monitor for burning/painful urination. -Problems: Resident #4 is at risk of pressure ulcer related to history of pressure ulcers/impaired mobility. -Interventions included: check skin for redness, skin tears, swelling or pressure areas. Report any signs of skin breakdown -Problems: Resident #4 is at risk for infection related to indwelling catheter -Interventions included: clean around catheter with soap and water or may use wipes as appropriate/desired by patient; keep tubing below level of bladder and fee of kinks or twists; report any signs of infection, wash hands before and after procedure. Interview on 5/19/2022 at 11:15 AM, Resident #4 was lying in bed on her back. She was alert, oriented and said she always has back pain. She prefers to have bed baths right now due to back pain. She was wearing adult brief and foley catheter was hanging of the side of the bed below the resident. There was yellow urine in the tubing and bag She had been very itchy in the perineal area and gets sores when sitting in feces for hours. She said she was changed before 8:30 AM. She stated this has been an issue of not receiving a thorough clean up ever. She stated she had a bath on Monday and thinks she is supposed to get them weekly. Observation on 5/19/2022 at 11:32 AM, with the help of CNA C, Resident #4's skin was observed. The entire perineal area: groin folds, labia area, extending to the buttocks was a diffused deep red color. There were multiple scattered red bumps along abdominal folds, left hip, buttocks, and groin area. The left upper outer hip had a long bright red, shiny area where the elastic of the brief contacts the skin. The foley catheter was secured onto the right thigh with a stat lock secure device. Interview on 5/19/2022 at 1:00 PM, Resident #4 stated prior to admitting to the facility she did not have any redness or itching. The itching started about one week ago. Prior to Monday's bath she had not had a bath for 3 weeks. Interview on 6/02/2022 at 3:00 PM, LVN D stated she did a head-to- toe skin assessment on Resident #4 on 5/19/2022 after Surveyor assessed Resident #4's skin. LVN D was unable to recall anything else about the resident's skin condition other than a wound to the right buttocks that had a dressing. LVN D noted on a body form drawing that Resident #4 had discoloration to the left arm, a foley catheter and wound on the right buttocks. LVN D's assessment of Resident #4's skin condition was unlike the Surveyor's assessment. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #4 nursing clinical notes dated 6/04/2022 at 12:48 PM and written by LVN E read in part: The family .requested that Resident #4 be sent to the hospital because her UTI has worsened .orders received to send the resident to the ER for evaluation and treatment . Record review of Resident #4's hospital records dated 6/04/2022 at 7:43 PM read in part .the resident was admitted to the ICU with suspected intracranial hemorrhage . Record review of Resident #4's hospital MD progress note dated 06/09/2022 at 1:37 PM read in part .1. Altered mental status . acute metabolic encephalopathy likely due to urinary tract infection .4. Complicated UTI, due to chronic indwelling Foley catheter, urine culture positive for Klebsiella pneumonia, ESBL and E. coli . Record review of Resident #4 hospital discharge papers indicated she was transferred back to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Observation on 6/15/2022 at 2:10 PM of incontinent care for Resident #4. There was a very strong odor in the room. There was no PPE cart or contact isolation signage. The resident was awake and slightly confused. CNA B assembled clean supplies on the bedside table, donned clean gloves and explained to the resident that she was going to clean her up. The foley bag had 350cc of amber urine. The bag was dated 6/15/22. CNA B moved the foley bag and placed it on top of the bed sheet to the right of the resident's legs. She unfastened the brief. Resident #4's groin, labia, entire perineal area had widespread redness. There were faded red spots beneath the abdominal pannus. Both hip areas were clear with small amounts of flaky skin. CNA B cleanses the right groin with a wipe, folded the wipe and cleansed the left groin. She assisted the resident to roll to the right side in order to change the bed linen. She removed the linen and replaced with clean linen. CNA B removed the soiled brief. The brief had serosanguineous drainage. She placed in the trash bag. Resident #4's skin on her bottom had areas that were open and bleeding. There was no dressing. The surrounding skin was red, excoriated, widespread from vagina, across buttocks and up to lower lumbar region. The edges of the red area on lower back was dry and flaky. RN A entered the room with a measuring hat, box of clean gloves and privacy cover for the foley bag then left the room. CNA E entered room and assisted. CNA E washed hands at the bathroom sink and donned clean gloves and assisted by keeping the resident turned to her right side. CNA B cleaned the perianal area with a wipe starting from front to back, folded the wipe and cleansed the perianal area again, there was some stool, folded and wiped the sacral area. CNA B removed gloves and donned clean gloves. The foley catheter anchoring device was wrapped and stuck around the foley catheter very close to the vagina area. CNA E gently removed the adhesive anchor device. The resident said ouch once. CNA B used one wipe to cleanse the lower vagina region moving from front to back, folded the wipe and cleansed the same area again. The resident said ow, you don't listen. With the same gloves CNA B applied the Calazime lotion to the buttocks and lower lumbar region then removed the gloves. CNA B started to don a new pair of gloves when CNA E reminded she needed to wash her hands first. CNA B washed her hands at the bathroom sink. CNA B donned clean gloves, positioned the clean brief under the resident and turned resident onto her back. There was white substance visible in the folds of the vagina. The foley bag was moved to the left side of the resident on the bed. The resident was turned to her left side. Red excoriated skin was visible on right buttocks and lumbar region. CNA B applied Calazime cream to inside groin areas and skin over the vulva. She removed gloves, washed hands, donned new gloves. Without first spreading the labia, CNA B cleaned the foley catheter, starting from the patient outward with a cleansing wipe. She then secured the brief: opened brief again, repositioned the catheter and secured brief again. CNA B removed Resident #4 soiled gown and dressed the resident in a clean gown. The resident was turned to her left side a wedge placed under her back and linen adjusted. The foley tubing and bag was hung on bed frame to the left and below the resident then CNA B removed gloves. Foley bag had approximately 700cc urine. Interview on 6/15/2022 at 3:00 PM CNA B stated she was taught to fold the wipes and use a second time, by the State and that this was facility policy. When asked why she did not spread the labia and clean within the folds, she stated she did spread the labia and wiped inside. When asked why she applied cream before cleaning the catheter she stated she did not want to get cream onto the catheter. When asked why she did not sanitize hands between glove changes she stated she did wash her hands three times and the reason for hand washing or hand sanitizing was for infection control. When asked, what did she do to prevent urine from backing up into the resident and help prevent a UTI she stated she made sure to straighten the catheter and tubing prior to placing it on the bed. CNA B said she planned to empty but will need alcohol pad first. She said she would notify the nurse that Resident #4 will need a new anchor device for the foley catheter. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/15/2022 at 4:22 PM, the DON was notified of Resident #4's incontinent care performed by CNA B. DON stated during peri care she preferred to use one cleansing wipe per area. She expects the nursing staff to hook the foley bag to the same side of the bed the resident is turned to so not to cross over the leg during incontinent care. The foley bag is always positioned below the patient to prevent backflow of urine and prevent infection. The foley bag and tubing should never be placed on the bed due to the risk of urine backflow into the resident. She stated to prevent infection, hand sanitizing is performed after changing gloves, any time the gloves are visibly soiled, when entering and exiting a resident room, after removing the soiled brief and prior to and after applying barrier cream. The stat lock is used all the time to prevent tugging of the foley catheter, to maintain position, to avoid trauma which could lead to pain. LVN D is responsible for checking microorganisms and isolation depends on the microorganism and resistance to antibiotics. She stated everyone can report signs and symptoms of urinary infection such as burning, frequency, discoloration, nausea, and odors. The DON stated she will start in-services specifically covering UTIs and that spot checks are done by the nurses to watch how the CNAs are performing incontinent care. She stated spot checks will need to be done daily. Interview on 6/16/2022 at 2:00 PM, the Regional Clinical Services Director stated Resident #4 did readmit with a UTI. Contact isolation is used for residents with C-diff or multidrug resistant bacteria ESBL (extended spectrum beta-lactamase) for example. Resident #4 will be put into contact isolation right away because of the ESBL in her urine. The Regional Clinical Service Director also said he would have to research regarding the discrepancies on the weekly skin assessment descriptions, that the facility was aware the wounds are not descriptive and had hired a new wound care nurse. Interview on 6/16/2022 at 2:00 PM the Administrator stated he spoke with CNA B after performing incontinent care for Resident #4 on 6/15/2022 at 2:00 PM and said that CNA B did use gloves when emptying the foley bag. Record review of the facility policy and procedure titled Catheter Care, Cantex Continuing Care Network, updated March 2019 read in part: Responsibility - Licensed Nurse and Nursing Assistant. Purpose - To prevent infection and to reduce irritation Procedure - wash your hands, gather equipment, and take to bedside .put on gloves, cleanse perineal area with warm wash towel. Wash perineum well with soap and warm water, taking care to wash from front to back. May use wipes in place of soap and water .Cleanse area at catheter insertion well .pat dry gently with clean towel .discard disposable equipment properly. Ensure leg strap in place to secure tubing .wash your hands . Record review of the facility policy and procedure titled Handwashing, Cantex Continuing Care Network, revised March 2019 read in part: Guidelines, Standards of Practice/Hand washing - Hand washing is the single most important means of preventing the spread of infection After Patient contact wash hands with soap and running water May use hand sanitizing gel in place of soap and water. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Record review of facility policy and procedure titled Perineal Care Protocol, Cantex Continuing Care Network, February 2022 read in part: .Cleansing the perineal area between showers or baths help prevent irritation, infection and skin breakdown as well as keeping the patient comfortable Assemble equipment and supplies on bedside .will need .hand sanitizer .Wash hands; apply gloves .remove soiled clothing and/or brief, if needed clean soiled areas first by wiping off fecal material with wipes. Remove gloves, sanitize hands, and apply new gloves Using a new wipe, wash, beginning from center of abdomen, and clean outwards from front to side separate labia with hand to expose urethral meatus. Use one stroke method to clean front to back. Wash labia major and skin folds Using a wipe, cleanse the inside of the first groin area then get a new wipe and cleanse the other groin area .Ask patient .assume side lying position .Using a new wipe, wash from vagina toward rectum with one stroke, front to back, repeat if necessary with a wipe as all feces must be cleaned off. With new wipe, cleanse the entire buttock area and surrounding hip area. Turn over surface of wipe to cleanse other side of buttock. Wash/sanitize hands. Apply clean gloves .Report any skin concerns to Charge Nurse . Record review of CNA A's staff competency check list for incontinent care dated 4/26/2022 and CNA B's staff competency check list for incontinent care dated 5/20/2022, read in part: .3. Assemble equipment and supplies on bedside .4. Wash hands and apply gloves .6. Assist patient to supine position and remove soiled clothing and/or brief .7. Remove gloves, sanitize hands, and apply new gloves .Female Perineal Care .2. Wash, beginning from center of abdomen and clean outwards from front to side. Use new wipe per area .3. Wash from front towards rectum .using clean stroke. Never wipe back and forth from the back to the top .4. Separate labia with and to expose urethral meatus. Use one stroke method to clean front to back. 5. Wash labia major and skin folds 6. Cleanse inside of the first groin area downward from top to bottom, then get a new wipe and cleanse the other groin area .7. If catheter present, stabilize the catheter, then gently wipe the catheter tubing with new wipe from the meatus outward .10. With new wipe, cleanse the entire buttock area and surrounding hip area. Turn over surface of wipe to cleanse other side of buttock .11. Wash/sanitize hands. Apply clean gloves 12. Position brief under patient. Apply barrier cream to perineal and buttock area . fasten clean brief .13 wash hands. Record review of the facility policy and procedure titled Quick Reference for isolation Precautions, Cantex Continuing Care Network, Revised March 2019 read in part: .Contact Precautions, In addition to Standard Precautions, Use Contact Precautions for Patients known or suspected to have serious illnesses easily transmitted by direct Patient contact or by contact with items in the Patient's environment. Examples of such illnesses include: .skin, wound infections or colonization with multidrug-resistant bacteria by the infection control program, based on current state, regional or national recommendations, to be of special clinical and epidemiologic si [TRUNCATED]