STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675882	A. Building B. Wing	12/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Gardens of Allen	310 S Jupiter Allen, TX 75002

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #1 and Resident #2) of five residents reviewed for Respiratory Care. 1. The facility failed to ensure that Resident #1's breathing mask for nebulization was properly stored on 12/07/2024. 2. The facility failed to ensure that Resident #2's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored on 12/07/2024. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #1's Face Sheet, dated 12/07/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #1 was diagnosed with chronic respiratory failure (airway to lungs becomes narrow and damaged) with hypoxia (low oxygen level). Review of Resident #1's Comprehensive MDS Assessment, dated 10/15/2024, reflected the resident was cognitively intact with a BIMS score of 15. Resident #1's Comprehensive MDS Assessment listed chronic lung disease as one the of the resident's active diagnosis. Review of Resident #1's Comprehensive Care Plan, dated 10/19/2024, reflected the resident had respiratory failure and one of the interventions was give aerosol (fine spray or mist used to deliver medications) or bronchodilators (medication used to open the airways) as ordered. Review of Resident #1's Physician Order, dated 07/08/2024, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally four times a day for antiasthmatics. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/07/2024 at 3:01 PM revealed Resident #1 was in her bed, awake. It was observed that there was a nebulizer machine on top of the resident's right-side table and a breathing mask was connected to the machine. The breathing mask was on top of the machine and was not bagged. The resident said she was on breathing treatment four times a day because of her breathing problem. She said the nurse would put it on and would take it off. She said she do not know where the nurse would put it after he would take it off. She said she was never told to put the breathing mask in a plastic bag and said it was not her responsibility to put it on a bag. She said she do not know when the breathing mask was last changed. 2. Review of Resident #2's Face Sheet, dated 12/07/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #2 was diagnosed with chronic respiratory failure with hypoxia and muscle weakness. Review of Resident #2's Comprehensive MDS Assessment, dated 10/22/2024, reflected the resident was cognitively intact with a BIMS score of 13. Resident #2's Comprehensive MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #2's Comprehensive Care Plan, dated 10/27/2024, reflected the resident had respiratory failure with hypoxia and one of the interventions was to give oxygen therapy as ordered by the physician. Review of Resident #2's Physician Order, dated 12/07/2023, reflected O2 @ 2L via NC CONTINUOUS every shift for SOB. Observation on 12/07/2024 at 3:11 PM revealed Resident #2 was in her bed, awake. Resident #2 was wearing the nasal cannula and receiving oxygen. It was also observed that the resident had a wheelchair at bedside with a portable oxygen tank at the back. A nasal cannula was noted connected to the portable oxygen tank and the nasal cannula was hanging on the wheelchair's right wheel. The nasal cannula was not bagged and almost touching the right wheel of the wheelchair. In an interview with CNA B on 12/07/2024 at 3:49 PM, CNA B stated the wheelchair was Resident #2's wheelchair. He said the nasal cannula should not be hanging by the wheel because it would get dirty. He said he would tell the nurse the nasal cannula was hanging by the wheel. Observation and interview with RN A on 12/07/2024 at 3:56 PM, RN A stated the breathing mask and the nasal cannula should be inside a clean bag when not in use to protect them from transfer of germs and probable infection. RN A entered Resident #1's room and saw the resident's breathing mask sitting on top of the nebulizer machine. He disconnected the breathing mask, threw it the trash can and said he would get a new one, and would put the breathing mask inside a bag. He said he administered the resident's breathing treatment around 3 PM and the resident must have removed it when it was done. He said he should have checked if the resident was done, cleaned the breathing mask and put it inside the bag. RN A went out of Resident #1's room. After leaving Resident #1's room, he went inside Resident #2's room, and saw the nasal cannula was hanging at the back at the wheel of the wheelchair. RN A disconnected Resident #2's nasal cannula and threw it in the trash can. He said he would also replace it. He said he did not notice the nasal cannula was hanging and almost touching the wheel of the wheelchair. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 12/07/2024 at 4:48 PM, the Administrator stated the breathing mask and the nasal cannula should be kept clean to prevent any respiratory infection. He said he would coordinate with the DON regarding the needed in-service about respiratory care. He said the expectation was for the staff to bag the breathing mask and the nasal cannula every time the resident was not using it. In an interview with the DON on 12/07/2024 at 5:17 PM, the DON stated the breathing mask and the nasal cannula should be stored properly when not in use to keep them clean. She said if the breathing mask and the nasal cannula were not bagged, exposed, or touching surfaces that were not clean, there could be cross contamination, respiratory infection, and compromised oxygen administration. She said the expectation was for the staff to be mindful in making sure that the breathing mask and the nasal cannula was properly stored. She said she would make an in-service and re-educate the staff about storing the breathing mask and the nasal cannula properly. Facility's policy for bagging the nasal cannula requested via email to the Administrator on 12/07/2024 at 4:30 PM but was not provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #2) of five residents reviewed for Infection Control. The facility failed to ensure that CNA B changed his gloves and performed hand hygiene while providing incontinent care to Resident #2 on 12/07/2024. This failure could place the residents at risk of cross-contamination and development of infections. Findings included: Review of Resident #2's Face Sheet, dated 12/07/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #2 was diagnosed with muscle weakness and muscle atrophy (decrease in size of a body part). Review of Resident #2's Comprehensive MDS Assessment, dated 10/22/2024, reflected the resident was cognitively intact with a BIMS score of 13. Resident #2's Comprehensive MDS Assessment indicated the resident needed maximal assistance for toileting. Review of Resident #2's Comprehensive Care Plan, dated 10/27/2024, reflected the resident had an ADL self-care performance deficit related to weakness and one of the interventions was provide assistance with personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA B on 12/07/2024 at 3:49 PM revealed CNA B was about to provide Resident #2's incontinent care. CNA B took with him a box of gloves, wipes, and a brief inside the room and placed them on the resident's overbed table. He did not place any hand sanitizer on the overbed table. He washed his hands and put on a pair of gloves. CNA B raised the bed and lowered the head of the bed. He unfastened the resident's brief, pushed it between the resident's legs, and cleaned the resident's perineal area (area between the thighs) using the front to back technique. After cleaning the perineal area, he took off his gloves, threw them to the trash can, and put on a new pair of gloves. He did not sanitize in between changing of gloves. He assisted the resident to roll towards the wall and started to clean the resident's bottom. After cleaning the resident's bottom, he rolled the soiled brief, pulled it, and threw it in the trash can. He changed his gloves but did not sanitize his hands before putting on a pair of gloves. After changing his gloves, CNA B touched the trash can and tied the plastic bag inside the trash can into a knot. After tying the plastic bag, CNA B took the new brief from the overbed table, put it under the resident, and fixed it. He did not change his gloves after touching the trash can and before touching the new brief. When CNA B was done with incontinent care, he took off his gloves and washed his hands. He stated he did wash his hands before and after incontinent care and he also changed his gloves after cleaning the resident the resident's perineal area and bottom. He said he was supposed to sanitize or wash his hands when he changed his glove to be sure his hands were clean when he put on the new gloves. He said he should have changed his gloves after touching the trash can because the trash can is dirty. He said his action could result to cross contamination and infection. He said he had in-services about hand hygiene and infection control but was not able to apply it. In an interview with the Administrator on 12/07/2024 at 4:48 AM, the Administrator stated staff should wash their hands and change their gloves when needed to prevent transfer of germs and infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control and hand hygiene. He said he would coordinate with the DON to do in-services about hand hygiene and infection control. In an interview with the DON on 12/07/2024 at 5:17 PM, the DON stated hand hygiene was the most efficient way to prevent cross contamination and infection. She said staff should do hand hygiene before and after incontinent care and also when gloves were changed. She also the gloves should be changed after touching the soiled brief and after touching the trash to prevent transfer of microorganisms to any clean brief. She said the expectation was for the staff to change their gloves when going from dirty to clean and to do hand hygiene when changing the gloves. She said she would do an in-service for infection control and hand hygiene. She said she would personally monitor them for Review of facility policy, Handwashing/Hand Hygiene 2001 MED-PASS, Inc. revised December 22, 2023 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . 7. Use an alcohol-based hand rub . f. Before donning sterile gloves . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids k. After handling used dressings, contaminated equipment, etc.